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THE REPORT OF THE MASSACHUSETTS MENTAL HEALTH PLANNING PROJECT

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MENTAL HEALTH FOR MASSACHUSETTS

THE REPORT OF THE MASSACHUSETTS MENTAL HEALTH PLANNING PROJECT

The Planning Project was conducted by The Medical Foundation, Inc.
under a contract with the Massachusetts Department of Mental Health.

The Project was funded by a grant-in-aid from
the National Institute of Mental Health with matching funds from
the Massachusetts Department of Mental Health.

MASSACHUSETTS MENTAL HEALTH PLANNING PROJECT
227 COMMONWEALTH AVENUE
BOSTON, MASSACHUSETTS 02116

June 30, 1965

His Excellency John A. Volpe
Governor of the Commonwealth
State House
Boston, Massachusetts

Dear Governor Volpe:

I have the honor to submit the report of the Advisory Council of the Massachusetts Mental Health Planning Project. This report supplements and continues the work of your 1962 Conference on Mental Health.

The Planning Project, which was financed through the 1963 Appropriations Act for the Department of Health, Education and Welfare (subsequently renewed for 1964), commenced on July 1, 1963. Its goal was to develop plans for the improvement of the mental health of the people through community based mental health programs.

This Advisory Council was appointed by your predecessor, The Honorable Endicott Peabody, in March, 1964. Our charge was to receive and review periodic reports of the staff and the problem-centered task forces. We were also given the responsibility of reviewing, studying and approving or revising the comprehensive plan for a community mental health program submitted by the project staff.

For many months before our appointment and for the duration of the project, basic data have been collected and policy positions have been established through the efforts of task forces, community surveys, public hearings and studies emanating from the project itself. This report, therefore, represents not only the considered judgment of the 67 Advisory Council members, but also reflects the thinking of more than 300 people throughout the Commonwealth who served on task forces, and the literally thousands of citizens, both lay and professional, who appeared at public hearings, participated in community studies, answered questionnaires and submitted statements of position.

The late President John F. Kennedy proposed a ". . . mental health program . . . which (will) make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society." It is to the achievement of these ends that our efforts have been directed.

This study sprang directly from the inspiration of the work of the Joint Commission on Mental Illness and Health. The words which closed the letter of transmittal of its final report to the United States Congress are as appropriate here as they were five years ago.

> "Mental illness involves so many complexities—biological, chemical, psychological, and social—that we do not presume to present wholly definitive conclusions or universally approved recommendations. But the study has been thorough and conscientious. Its proposals are bold and challenging. It remains for legislators and leaders in the mental health field to select for implementation those recommendations that seem immediately practicable and to press for the realization of others so far as they appear urgent and attainable."

With a similar sentiment we transmit this document for your, and the Commonwealth's consideration.

Respectfully submitted,

Harry C. Solomon

HARRY C. SOLOMON, M.D.
Chairman of the Advisory Council

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ACKNOWLEDGEMENTS

Authors customarily acknowledge the assistance of others. Although the tradition for Project Directors is not as clearly established, it is an opportunity which I do not intend to ignore.

It is gratifying to be able to acknowledge all the people who have made this Project possible and who have contributed to its deliberations and conclusions. Literally more than a thousand have participated. Naming them all is not possible, but some must be cited.

Dr. Harry C. Solomon, who had the courage to contract the entire state planning operation to a voluntary organization; his staff, who contributed effectively to the Project; the Project staff (and the many names are listed in this report), who participated vigorously and enthusiastically throughout our deliberations, all deserve special thanks.

Mrs. Elizabeth Hawes, the Project's Administrative Assistant, was an indefatigable participant. Her dedication, vigor and ability were especially noteworthy and necessary.

Advisory Council members, and especially those who served on the Steering Committee, as well as the members of the 18 task forces, all deserve my particular gratitude. Without them there would be no final report.

Significant contributions were made by many organizations including the Massachusetts Association for Mental Health and its many affiliates, representatives of many state departments, the Massachusetts Taxpayers Association, the Community Chests and Councils throughout the state, our planning colleagues in education, many universities, and the professional associations of social workers, psychologists and physicians.

Citizens from all walks of life cared and helped. Given an opportunity to express their concern, constructive suggestions were received.

Our Project was conducted during two different state administrations. Complete cooperation was received throughout from both.

Finally, a very personal acknowledgment must be extended to the Board of Directors of The Medical Foundation, Inc., who supported and encouraged me in this endeavor.

For her continued sufferance, I again thank my wife.

Harold W. Demone, Jr.
Director
Massachusetts Mental Health Planning Project

June 30, 1965

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A CAPSULE REPORT AND PRINCIPAL RECOMMENDATIONS

No Distant Hospitals

Public and private groups throughout this country will be creating new community mental health programs in the immediate future. A growing proportion of the mentally ill will no longer be relegated to distant hospitals. Patients will remain at home; be treated at home; and become well at home. Community mental health programs will emphasize rapid and effective diagnostic procedures, more varied treatment approaches and the development of preventive measures.

Local facilities will be created to help people in their own community. This reflects a national effort to answer the late President John F. Kennedy's plea to apply medical knowledge and social insights so that the vast majority of the mentally ill can eventually achieve a wholesome and constructive social adjustment. The quick response to the President's plea indicates that a variety of social and political developments created a lasting impact.

Our citizen's increasingly genuine concern for the mentally ill is part of society's general concern for the handicapped and disadvantaged. Especially imperative is the participation of all levels of society in the prevention and treatment of mental illness. Ultimately, the community itself plays the most significant role in helping or hindering the disturbed individual.

To be most effective, the skills of mental health professionals must be utilized in conjunction with a myriad of other community resources. Without the cooperation of all forces, including lay, professional, and governmental, the success of the mental health professional will always be limited.

The Massachusetts Mental Health Planning Project was established in the spring of 1963 to develop a comprehensive plan encompassing a bold new approach to the provision of mental health services. Plans proposed in this final report were produced through the collective efforts of several hundred citizens who contributed an incalculable amount of time toward their development. Our broad-ranging recommendations reflect a consensus achieved as a result of two years of deliberation.

A Complex Challenge

In seeking to develop a statewide program for comprehensive community mental health, the Advisory Council of the Massachusetts Mental Health Planning Project accepted a complex challenge.

There was a need to document in depth the dimensions of the problem and to assess the state's existing and potential resources for achieving the stated goals. Next, it was necessary to involve community and professional leaders in the development of specific plans directed toward specific problem areas. Finally, it was necessary to draft recommendations scaled to the dimensions of the problem and tailored to the limitations of practicality.

We had two simultaneous goals:

- to be comprehensive in order to advance the attack on all fronts;
- to be sufficiently detailed to give direction for concrete action.

The present report represents an attempt to meet these goals. Detailed reports of 18 task forces where problem areas were intensively studied, are available from the Department of Mental Health. They present more detail about specific problems as well as the diversity of opinion about many issues.

Elements of a Community Mental Health Program

Each community mental health program should have its own unique character and reflect the special needs and resources of the area. Its ability to attract and utilize scarce professional personnel will be one measure of its success. Its capacity to relate effectively to the array of other community resources will be another significant component. Its quality and range of services will be the basic ingredient.

A comprehensive community mental health program should offer the following services for all needing them, under one or more institutional auspices:

- Inpatient services for a limited time.
- 24-hour emergency services.
- Outpatient services.
- Partial hospitalization for day care and night care programs.
- Precare and aftercare service, including foster homes, halfway houses and home visiting.
- Continuing care either locally or within a reasonable distance.
- Community services in the form of consultation and education.
- Diagnostic services in the form of extensive examinations.
- Rehabilitative services in vocational, education and social areas.
- Training for all types of personnel.
- Research and evaluation of a variety of types.

Dispersion of Resources

In planning for future community mental health programs certain fundamental principles have been adopted. To effectively reach those who need mental health services, there must be a decentralization or dispersion of resources. In geographic terms, this can be accomplished by establishing the 37 community mental health areas described in the section on Regionalization. Equally important, the mental health program must be socially and psychologically available. The patient's use of services generally decreases with increasing physical distance from the location of facilities. While this holds true for everyone, it is especially acute for the economically and socially underprivileged whose needs for effective mental health services are most pressing and most severely neglected.

A Program is More Than a Building

Even in those geographic areas where a substantial battery of mental health services will be provided under one roof, it is essential to recognize the complex nature of the community and its institutions.

Mental health is an issue with which every institution in our society is involved; the family, the school, the church, the employer, organized labor, the hospital, the settlement house, the police, the drug store, even the poolroom and the bar. Independent of its location and its sponsorship, the community mental health program must relate to and direct its efforts toward other significant institutions.

A separate organizational factor is that even the essential elements of a community mental health program may not be under one roof or even under a single sponsorship. In these circumstances, the various services must be linked in such a manner as to assure continuity of care. Patients should not leave one service and find the door to the next needed service blocked by administrative barriers. The precise manner in which services are coordinated in each area cannot be determined at the state level, although they may cooperate. Basically, this issue must be determined locally.

Flexibility

In view of the fact that we are treading on relatively new ground in the field of community mental health, we strongly urge that the issues remain open to discussion and that the programs be flexible. In effect, we are functioning with considerable experience, but not with completely informed judgment. We must insure the possibility of increased knowledge and improved programs through:

- a systematic and well-supported program of basic research in mental health.
- a careful evaluation of programs in order to learn from successes and failures.
- an opportunity for experimental demonstrations that can depart from conventional procedures and provide a constantly expanding potential in community mental health services.

Community Involvement

All community facilities and professional personnel must be involved to the maximum degree in the development, fulfillment and change in any program that is truly a community mental health program. In addition, community mental health programs must lead to increased awareness of the mental health implications of diverse activities such as education, medical practice, pastoral counseling, social service and legislation.

One vital method of involvement is to establish area mental health boards, regional committees and a state advisory council. Then, citizens could actively participate in mental health programming and development. This will also enhance the principle of decentralization.

Coordinating Responsibility

Operation of a community mental health program does not require a single physical location or sponsor. However, it does require constant and dedicated coordination to ensure that no service gaps exist and that continuity of care is provided. A crucial function of the mental health center will be to act as a control system for the patient and his family by maintaining liaison among the various services and programs. Stimulation of new services, assisting in the improvement of existing services and reaching out to all of the agencies having the potential of giving care in the community loom as significantly in the center's responsibilities as the provision of clinical services.

Progress in the Development of Community Mental Health Centers

For the last seven years, the Massachusetts Department of Mental Health has been planning for comprehensive community mental health programs. This preceded the federal guidelines by about five years and specific developments can be noted.

The Massachusetts General Court has already allocated funds for the construction of comprehensive centers in three areas: Lowell, Fall River and the Government Center in Boston. All three centers will be operated in collaboration with general hospitals.

Funds for architectural studies have been granted for three more centers; at the Boston University Medical Center, in Springfield and on the South Shore (Quincy). As with the three programs in the construction phase, all will be comprehensive. The Boston University and Springfield programs will be operated in cooperation with general hospitals.

Nominal planning funds have been made available for the Berkshire area and prearchitectural studies are underway. In addition, discussions are currently in progress with representatives of several additional community mental health areas.

Another important element in this network is the proposed modification of the 12 existing state hospitals. The seven areas described above (Lowell, Fall River, the Government Center, Boston University Medical Center, the South Shore, Springfield, and the Berkshires) contain approximately one-fourth of the state's population. As programs are developed in these, and other areas, the demand for services at the 12 state hospitals will diminish and allow them to begin the necessary adjustment of their institutions into a combined community mental health center and continuing care institution. Worcester and Boston State Hospitals are examples of institutions where many of the necessary program adjustments are underway.

A Ten-Year Plan

Plans contained in this document propose evolutionary changes. As each of the 37 community mental health areas begins to develop new comprehensive programs, or fills some of the necessary gaps in existing programs, the burden on other facilities will be lightened. In turn, this will allow modification of programs in response to changing needs, developing skills and new tools.

Two or three new programs should be implemented each year. At the rate of five new programs every two years for ten years, 25 mental health programs will be developed which will contain the basic elements necessary for a comprehensive program. This, in turn, will allow the 12 state hospitals to convert their programs. By 1975, the transformation should be nearly complete.

As a guideline for this development, priorities based on a study of needs and resources have been

provided as an integral part of this document. Special attention should be given to the high-priority areas.

Based on federal construction allocations through 1967, and assuming the continuation of grants, we estimate that the federal government will make available matching capital funds to cover about one-third of the costs. It will be necessary for private sources, municipal and state government (individually or collectively) to match the federal allocations.

Financial Issues

The Advisory Council recognizes the keen competition for limited public and voluntary funds for community purposes. Of paramount consideration in the use of such funds must be the desires of the people. Furthermore, increased expenditures in areas such as public education, welfare, public health, rehabilitation and youth service, and other programs are related to the physical, social and mental well-being of the citizens of Massachusetts and are of importance in the development of a mentally sound population. Similarly, other social, health, welfare and education programs are directly dependent upon the availability of effective mental health programs.

The dilemma and responsibility of the formal mental health apparatus nevertheless remains. Over a number of years the proportion of the state budget expended for mental health purposes has been declining. Yet, in addition to these other resources, it is likely that the Commonwealth of Massachusetts will need to increase expenditures substantially in the next decade in order to meet the goals established in this document. Assuming a continuation of the current growth of the state budget and the same proportion allocated for mental health, the Massachusetts Mental Health Department will soon not have enough funds to operate an effective mental health program.

A number of options can be considered. Perhaps all will be necessary:

- The state government will have to increase its appropriations in mental health.
- Cities and towns will need to increase their share of the responsibility.
- Increasing federal funds will be needed.
- Coverage of psychiatric disability in voluntary insurance plans will need to be extended.
- The proposed federal medicare programs for psychiatric disability must be used to its fullest.
- Private systems of care must be expanded.

None of this will be easy. However, we feel impelled to be honest and direct with our fellow citizens. As with any beneficial program, adequate mental health services will cost money:

- Starting in 1966, the budget will need to increase by at least $3 million a year for operating and administrative costs alone.
- By 1970, the budget of the Department of Mental Health will need to be at least $120 million.
- By 1975, the budget will need at least $150 million, and probably more.

Issues in Manpower and Training

Plans for training and manpower needs for mental health personnel in Massachusetts for the next decade have been considered in the context of a major change in the scope and magnitude of the field of mental health. Problems will not be resolved easily despite some federal support for staff salaries and training.

In every profession under scrutiny—psychiatry, psychology, social work, nursing and occupational therapy—we are failing to meet present manpower needs. Unless dramatic changes occur, the manpower plight will be even more serious in future years. Even by 1966, when the Lowell and Fall River Mental Health Centers open for service, more than 300 professional and non-professional personnel will be needed.

Training institutions must enlarge and expand their programs. More important, the nature of the training must be adjusted to the new demands of community mental health. Existing personnel will need continuing education, job reclassification and upgrading and new mental health roles will need to be developed.

Current methods of using manpower should be sharply examined.

Massachusetts need not fall behind. We possess a unique combination of outstanding universities and clinical facilities. It is incumbent upon us to exploit this potential for the benefit of our citizens.

Continued Planning

Three significant levels of continued planning are foreseeable immediately. One is at the level of each of the 37 community mental health areas; the second at the six regional levels; the third at the statewide level.

The Massachusetts Department of Mental Health, motivated by these planning activities, has requested in its budget a permanent planning unit, as described in the chapter on Administration. Any department whose budget is approaching 100 million dollars a year needs individuals who are freed from day-by-day administrative responsibilities to focus on broad planning for implementation. Annual cost of a planning unit would be one-tenth of one percent of the Department's annual budget. More than half of the states already have made such units a permanent part of their mental health authority. It is obviously important to coordinate with planning in mental retardation, general hospital construction, mass transportation, urban renewal, area development, crime and delinquency, alcoholism, aging, public welfare and public health.

Unless staff is made available for this specific assignment, the complex task of planning will not be accomplished.

At the regional and area level, the potentials for participation in community planning are enormous. Possible partners include groups such as community councils, mental health associations, medical societies, labor councils, councils on aging, committees on alcoholism, retardation associations and hospital boards. We strongly encourage the immediate development of ad hoc planning councils in each of the 37 mental

health areas whose function would be the identification of the nature of existing resources, the degree and quality of agency relationships and the fulfillment of service gaps.

No new money is needed for this latter effort. Only local citizens can make effective decisions about the needs of their own community.

Prospects for Progress

Our feeling is one of optimism. We believe we are at the crossroads and that modest success is near. Decisions already made by the Massachusetts General Court and the last four state administrations have been impressive. We are pleased by the expansion of the Massachusetts Blue Cross-Blue Shield program and by certain of the insurance plans developed by labor and industry to cover their members and employees.

Many general hospitals are already re-examining their programs and they are to be congratulated. Increasing interest being expressed by the professional organizations of physicians, social workers and psychologists is an extremely important trend. We urge other disciplines to also take action. Steps already taken by many communities as they begin to re-examine their facilities and needs are most impressive. Self-studies and local planning are fundamental to effective change.

Various statewide studies completed, now underway, or proposed in the general field of health, correction, education and welfare are an exciting development. Mental health services can only be as effective as their complementary services. They are all intimately related.

We believe that we are in the midst of a long, historical process of change in mental health. The impetus is with us. We hope that we will do it justice.

PRINCIPAL RECOMMENDATIONS

The Advisory Council is proposing a wide variety of recommendations as solutions to the problem of developing comprehensive community mental health programs. All require implementation. However, certain recommendations comprise the essential core about which all the others revolve.

The Advisory Council designates the following 15 as having the highest priority.

Failure to enact any one of them would adversely affect the forward movement of our total plan and its goal of comprehensive community mental health services.

Mental Health is the Community's Business

1. Community mental health programs should be organized in each of 37 designated areas to provide a comprehensive network of mental health services to local residents.

2. A reorganization of the Central Office of the Department of Mental Health is essential. Plans should include the development of regional offices and regional budgets in order to decentralize effectively the mental health organization and services of the state and bring them closer to the community.

3. An effective and viable system of citizen participation through membership on local boards, regional committees and a state mental health council is required to decentralize services and to promote an active partnership between private, community and state mental health efforts.

4. A marked and immediate increase in state and federal appropriations is fundamental if the development of comprehensive community health programs is to proceed with dispatch and to accomplish a reduction in admission rates to large state mental hospitals and help to prevent mental illness in the future. Financial support for increased mental health services dictates that insurance organizations expand their coverage of the cost of mental illness.

Mental Health Services Should Be Comprehensive, Nondiscriminatory and Available Locally

5. Consultation, education and prevention services, as well as necessary clinical services to mentally ill individuals, should be expanded among all the community mental health programs throughout the state.

6. Residential treatment services for the severely emotionally-disturbed child, who is temporarily unable to live at home, should be established in each of the six major regions of the state.

7. Comprehensive mental health care implies a commitment to serve all in need. Admission and treatment policies and regulations within the 37 community mental health programs should be nondiscriminatory and should include responsibility for service to groups such as the aged, the addictive drug user, the alcoholic, the offender and others who historically have been overlooked.

8. Barnstable, Haverhill, Lynn, New Bedford, Plymouth and Springfield are the six communities having a combination of high need for mental health services and limited resources for community services. These communities require immediate attention from the Department of Mental Health toward meeting the gaps. However, present plans for the development of community mental health programs in each of the 37 areas should also be pressed to completion.

Mental Health Services Require Trained Professionals and New Knowledge

9. The Department of Mental Health should take the initiative in exploring the means for establishing formal affiliations between the proposed community mental health programs and the public and private universities throughout the state which direct successful professional and scientific degree programs in the mental health professions and related scientific fields.

10. Mental health training activities should be allocated additional funds amounting to not less than 2½% of the budget of the Department of Mental Health, to be administered through the Department.

11. Staff positions to administer training programs should be established in the Central Office of the Department of Mental Health.

12. Mental health research activities should be allocated additional state funds amounting to not less than 4% of the budget of the Department of Mental Health and to be administered through the Department of Mental Health.

Mental Health Leadership Requires New and Additional Personnel in the Department of Mental Health

13. A permanent planning division should be organized in the Central Office of the Department of Mental Health.

14. A leadership role in coordinating and organizing public and private mental health activities of a comprehensive nature throughout the state should be the task of specific personnel within the Department of Mental Health.

15. Present professional positions in the Department of Mental Health must be redefined, restructured and appropriately up-graded to implement the current and future goals of the Department of Mental Health for comprehensive mental health services.

BACKGROUND AND PROCEDURE

"I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill . . . which (will) make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society."

JOHN FITZGERALD KENNEDY
Presidential Message to Congress
February 5, 1963

Since June, 1963, official groups in all fifty states, plus the District of Columbia, Puerto Rico and the Virgin Islands, have been participants in the most exciting and comprehensive attacks on the problems of mental illness and mental health ever attempted in this nation on the statewide level. With the financial assistance of the federal government and additional support from state governments and other sources, each of these mental health planning projects are engaged in the process of developing a comprehensive community mental health plan. By September, 1965, each state was required to present a plan unique to its own needs, but within the broad concept of community mental health. This approach was designed to provide comprehensive services of both a preventive and treatment nature in the community.

In the two-year period 1963-1965, in excess of $8.4 million was expended and literally tens of thousands of people, lay and professional, were deeply involved. This was truly a concerted effort of the national community to find ways of meeting one of its most vexing problems.

Federal Background

The Congressional act which made the comprehensive mental health program possible was the most recent step in a sequence which commenced in 1946 when the National Mental Health Act was passed establishing the National Institute of Mental Health. This act, which also authorized grants-in-aid to states for community health programs, firmly established the principle of state-federal partnership in mental health. A second milestone was the Mental Health Study Act of 1955, which assigned the Joint Commission on Mental Illness and Health the mandate to survey the resources and to make recommendations for combatting mental illness in the United States. Dr. Jack Ewalt, then Massachusetts Commissioner of Mental Health, was the study director. On December 31, 1960, the Joint Commission transmitted its report to Congress. This document, published under the title *Action for Mental Health,* stimulated considerable response.[1] In January, 1961, the Surgeon General's Ad Hoc Committee on Planning Mental Health Facilities recommended "that the Governor of each state consider taking whatever steps are necessary to stimulate the development of a plan for mental health facilities."[2] In 1962, both the Conference of State and Territorial Mental Health Authorities and the Governor's Conference passed resolutions strongly urging allocation of funds to enable development of comprehensive state planning efforts directed to the eventual implementation of some of the emerging concepts in community mental health.

In response to the recommendations of these powerful groups and a deep interest in the problem evidenced by the late President Kennedy, the 87th Congress (as a part of the 1963 appropriation for the Department of Health, Education and Welfare) provided $4.2 million for grants-in-aid to states for financing comprehensive mental health planning at the state level for each of two years.

Although all the projects were directed toward the same basic goal—improvement of the mental health of the people through community rooted programs—the federal guidelines recognized "differences among the state . . . their mental health problems . . . their resources . . . history . . . size and their administrative arrangements."[3] Wide latitude was given to the states in developing project design, operational methods, staffing and priority setting. The principal limitation was against the use of planning funds for direct service, training of personnel or demonstration projects. Grants, ranging from a minimum of $50,000 to more than $280,000 annually (based on a previously determined grant-in-aid formula), were given to the "mental health authority" of each state. In Massachusetts, the first-year grant was $88,900; the second-year grant $86,400.

Goals of the Massachusetts Mental Health Planning Project

The grant proposal developed by the Massachusetts Department of Mental Health, as the state mental health authority, and submitted to the National Institute of Mental Health had three goals:

- A general aim of the Planning Project was to mobilize state, local, private and voluntary resources in order to stimulate greater community initiative and participation in the long-term solution to mental health problems.
- The development of a comprehensive master plan for coping with the community's mental health problems was the specific goal. This included the gathering and analyzing of data to allow the selection of goals, priorities, allocation patterns and methods for achieving selected aims.
- The establishment of a permanent planning mechanism within the Department of Mental Health was a goal with the future in mind.

[1] New York: Basic Books, 1961.

[2] Public Health Services, *Planning of Facilities for Mental Health Services* (Washington, D. C.: U. S. Dept. Hlth. Educ. Wel., January, 1961), p. 3.

[3] Public Health Service, National Institute of Mental Health, *Digest, State Mental Health Planning Grant Proposals, 1963* (Washington, D. C.: U. S. Department of Health, Education and Welfare, August, 1963), p. 60.

Major functions of a planning unit would include the utilization of systematically gathered data in the continuing evaluation and replanning required to meet changing needs and priorities and the stimulation of the active and continuing participation of all relevant state and community agencies and groups in the planning and decision-making process.

Early Decisions in Massachusetts

An initial decision was the choice of the setting in which the Massachusetts Mental Health Planning Project would be conducted. There was a choice between having plans made within the existing state mental health administrative structure, either with regular or specially hired personnel, or by some outside agent. In most states the job was done within the state structure, but in Massachusetts the latter choice was made.

Since the Department of Mental Health is the primary provider of mental health services within the Commonwealth, it was clear that one major concern of the Project would be the future directions to be taken by state-sponsored or financed programs. Thus, looking for a setting for the Project, these sharp issues were posed:

- Planners from outside the system would be able to stimulate change by providing fresh insights and unbiased evaluations without inhibiting vested interests or emotional commitment to current departmental programs. However, could they in a brief time master the vast amount of knowledge required to understand the state program, to say nothing of the delicate and complex historical and political milieu in which any large government program is set?
- Plans and programs have a better chance of success if they are developed by those responsible for implementation and are not perceived as being imposed from the outside. However, can personnel responsible for operations free themselves from the status quo when necessary and develop new structures and fresh approaches?

The final decision (made by the Commissioner of Mental Health) was that the Department of Mental Health contract with The Medical Foundation, Inc., a voluntary agency affiliated with United Funds and primarily involved in medical research and health education. Under the terms of the contract, The Medical Foundation accepted responsibility for developing the project design and all aspects of the study including the final report to the Governor and other appropriate agencies. The director of The Medical Foundation, a sociologist, served as project director on a part-time basis. Staff, especially assembled for this project, had a broad interdisciplinary background including social work, psychology, psychiatry, sociology, law and public heath.

Another early decision concerned the basic focus for the first stage of the project. It was assumed that the concept of community mental health programs implied a regional arrangement for the provision of services.[4] Initially, many states were divided into working regions and separate, somewhat independent, planning units were set up for each region. In Massachusetts, however, there was a discouraging history of attempts at regionalization of services; the most viable political and social entity remains the city or town. Cooperative provision of services has been resisted with some notable exceptions such as regional arrangements in the Boston area for public transportation, roads, recreation, and water, some regional schools, and two regional public health districts. Although it was recognized that the problem of regionalization would have to be faced, it was deferred until the second year. The work of the first year concentrated on identifying and studying mental health problem areas that were common to the entire state.

Development of Task Forces: The First Year

To implement the problem-centered approach, a series of statewide task forces were established and charged with developing recommendations in particular areas. Task forces were assembled for the following 14 problem areas: adult mentally ill, emotionally disturbed and psychotic children, mental retardation, alcoholism, drug addiction, adult crime and juvenile delinquency, epilepsy, aging, manpower, research, training, communications and health education, government structure, legislation, financing and occupational mental health.

The Project was philosophically committed to a policy of planning that was initiated within the community. It was not intended to use the community as a "rubber stamp" for plans developed by the staff, or to "stack the task forces" to reflect the particular biases of the staff. Rather than rely on staff judgment alone, key informants, both lay and professional, were interviewed during the first summer. They were asked two questions: "Whom would you include on a statewide task force concerned with your special area of interest?" "What issues do you think such a group should consider?" A primary goal of these interviews was to develop task forces composed of people who were knowledgeable and broadly representative of geographic areas of the state and who also represented a variety of disciplines. At the same time, these informants, who were leaders in the field, became acquainted with the project. Task force membership was derived from the names recommended in this process. Issues suggested by the informants served as a starting point for the work of the task forces.

Three hundred thirty persons were invited to serve on task forces and 98% accepted. They served as individuals, not as representatives of organizations, but they did bring the viewpoint of their agencies with them.

Participants included 32 state legislators, one member of the Governor's Council, 101 physicians, 47 social workers, 27 psychologists, 10 nurses, 10 sociologists and nine clergymen. Viewed from an organizational basis, 54 participants were from universities or public schools, 37 were from voluntary health and wel-

[4] These assumptions were later justified by the requirements of the construction regulations under federal mental health legislation which require that comprehensive services be provided for population areas of 75,000 to 200,000. See Federal Register, May 6, 1964, pp. 5951-5956.

fare associations, 29 were from the court, police and correctional system, 14 from business and industry, 11 from public health, 10 from mental health associations, six each from organized labor and the mass media, five each from rehabilitation, public welfare and the veterans administration and four from associations for retarded children. The Massachusetts Department of Mental Health was represented by 29 individuals from state hospitals and state schools, 14 from the central office, nine from clinics and four from the Division of Legal Medicine. In addition, many other organizations were represented by three or fewer persons as well as countless participants serving as individuals.

Originally it was planned to limit task force membership to 15. However, the broad base from which members were drawn made this difficult and most of the groups had more than 20 members. Because of their size, some of the groups were having difficulty coming to grips with the issues. Consequently, many were divided into small subcommittees, with each considering a different aspect of the task force responsibility. The smaller groups were able to focus better on their assignments.

Task forces employed a variety of methods and techniques. In addition to their own specialized knowledge and information available from agencies and the literature, they made use of consultants, site visits and surveys.

Initially it was planned to complete the task force assignments in eight months. As might be expected, an additional three to five months were required in most cases. Final task force reports were submitted to the Advisory Council, a group composed of 67 distinguished citizens throughout the state who served at the invitation of the Governor of Massachusetts.

Task Forces: The Second Year

During the second year the focus was on implementation. Task forces on administration, finance, legislation, and community mental health were established and worked from September, 1964 through May, 1965 with 46 persons participating. The training and manpower task force continued their deliberations.

Preparatory to the initiation of the four new task forces the Project staff spent the summer of 1964 in a review and synthesis of all the reports noting inadequacies, gaps and contradictions. The various studies were then collated and analyzed.

Basically, the attention of the second year task forces was directed to administrative arrangements, interagency cooperation, legislation, budgeting, facilities, personnel analysis and dissemination of professional and technical information, training and research.

Procedures followed those of the task forces for the first year.

As will be noted later in the chapter on mental retardation, the findings of this task force were assigned to the newly developed Massachusetts Mental Retardation Planning Project, which began in July of 1964 and is scheduled to report in September of 1966.

Contributions of the Task Forces

Collectively 18 task forces were established during the two years. The realities of developing a long-range plan within a relatively short period of time imposed severe limitations on the task force members. All were extremely busy with their regular occupational commitments. But no member of a task force came to his assignment empty-handed. All participated vigorously.

Despite the limitations under which they worked, the task forces submitted a series of extremely provocative reports and recommendations. In their entirety these reports are available from the Department of Mental Health.

In preparation for the writing of this report, the task force statements were made available to each Advisory Council member. Limitations of space, the need to balance recommendations which were at times conflicting and data augmented by findings derived from the Project's direct operational experience meant that sharp editing and abridgment occurred. The plan, as presented, represents only a segment of the total material developed by the task forces. In this sense there are two sets of reports, those of the individual task forces and this publication, the report of the Advisory Council.

Much of the task force material which is not included in this report will be of incalculable value to those charged with implementing the comprehensive plan.

Special Activities

Data Collection

A major activity involved the continuous collection of data throughout the life of the project. An intrinsic aspect of the final plan was the establishment of priorities for the use of scarce resources. These priorities were based on a determination of unmet needs, a cataloguing of services available through both private and governmental auspices and a thorough understanding of the demographic idiosyncrasies of areas throughout the state. Much data were obtained from previously completed studies, service statistics of the Department of Mental Health and cooperating agencies, as well as through the previously mentioned task force activities. More formal procedures were also undertaken, including a series of schedules and questionnaires designed to obtain data providing a broad and accurate picture of the differential use of various types of agencies and professionals in private practice.

In cooperation with the appropriate professional organizations, psychiatrists, psychologists, pediatricians, internists and general practitioners were surveyed. Psychiatrists and psychologists indicated the number of hours spent in private practice, the number of patients seen yearly, the ages of the patients, the waiting period and type of care offered. Pediatricians, internists and general practitioners detailed the extent of their practice they considered emotional disorders, the consultation utilized, attitudes toward the retarded and their opinion as to what phase of mental health care they felt particularly appropriate for their profession. The data obtained provided valuable insights into the adequacies and limitations of available services.

Relative over-all need for new mental health facilities among each of the state's 37 areas has been determined through the collection of data pertaining

to 19 different indices. It was possible to rank order each area's relative need on the basis of its socioeconomic standards, rate of mental and physical illness, degree of social pathology and extent of welfare need.

Information regarding the scope of existing mental health resources was gathered in a variety of ways, the foremost being the use of inventory schedules developed by the National Institute of Mental Health. Every psychiatric facility in the state, including those publicly and privately supported, returned a schedule indicating the types of services which it provided, the size of its staff and the number of patients treated in 1964. Similar information was obtained from family and social service agencies. Using the figures, it was possible to construct a profile of each area's existing resources (for children and adults) in providing the five service elements of a comprehensive mental health program.

For the most part, these data are quantitative. To obtain a qualitative picture of needs, more than 1,500 letters were sent to professional groups and agencies throughout the state. The list of recipients was not limited to typical mental health settings but included public welfare, rehabilitation, governmental and educational organizations. All were asked to state their views regarding the projected community mental health programs with particular emphasis on the programs' effect on their agency, discipline and community. More than 100 replies were received, ranging from one paragraph letters to substantial, well documented reports. This material was evaluated and integrated into the final report.

Self-Studies

Project staff also worked cooperatively with groups in 10 communities interested in developing self-studies of local mental health needs. These self-surveys were one of the ways in which natural regions of service and need were identified. As a result, community people were meaningfully involved in this phase of the planning process. Schedules were prepared in cooperation with the Department of Mental Health and the Massachusetts Committee on Children and Youth, with project staff serving as consultants. Studies were usually jointly sponsored by the local mental health association, community councils and other local groups. Not all communities were surveyed, but those areas conducting studies provided data from which extrapolations were made to the needs of communities throughout the state.

Community Relations

These self-studies were closely related to the third major continuing activity, the development of community relations. Involvement in the activities of local communities consumed a far greater proportion of staff time than was originally intended. One could not always rely on local resources to do the community organization job necessary to work through local rivalries and power struggles which impede free consideration of community problems. As Roland Warren suggested when speaking of the consultant's role, staff found its function "much broader than that of giving technical counsel on methodological matters."[5]

[5] Roland L. Warren, *Social Research Consultation* (New York: Russell Sage Foundation, 1963), p. 52.

Interpreting the Project (during its early phases) and discussing findings (during the closing phase) proved to be extremely demanding of staff time and skill. This seemed particularly true when staff reached out beyond the immediate environs of the Boston area and found themselves cast in the role of "those 'state' guys from Boston who are making plans for us."

Public Hearings

Another key community activity was the public hearing. As with other efforts involving communities, the purpose was twofold—to feed data into the decision-making process and to increase the local identification with and commitment to the concepts of community mental health. Again, the project staff worked with local resources developing community support, publicity, arranging for witnesses and the numerous other activities relevant to such an endeavor. Special credit should be given to the many local groups who handled all the community details.

At the hearings, witnesses presented testimony to a panel composed of Department of Mental Health officials, Planning Project personnel and several members of the Advisory Council. Witnesses were scheduled on an appointment basis, but time was allowed for anyone who wished to testify. These hearings were not intended as mass meeting promotional affairs although there was usually an audience of 20 to 50.

Efforts were made to obtain a broadly representative group of witnesses. In addition to public invitations through press and radio, key community people were specifically invited to testify. Approximately 30 people testified at each of the six hearings. They ranged from top elected municipal officials to educators and guidance counselors, from practicing professionals to parents of retarded children. As would be expected the testimony varied greatly, both in the scope of subject and quality of presentation, but the keen community interest and awareness of its needs was apparent. Hearings were conducted between April and December, 1964.

Relations with the Legislative Recess Commission on Mental Health

An important link established early in the development of the Project was with the legislature's Special Commission on Mental Health. Possessing mutual goals and responsible to different constituencies, the informal working relationship was of great value to the Planning Project. The legislative commission, freed from some of its customary responsibilities during the life of the Project, was able to concentrate its efforts on the recodification of the basic mental health statutes. In addition, the commission indicated a willingness to cooperate in the introduction of new legislation which might arise from the deliberations of the Planning Project.

Relations with Professional Groups

As previously stated, every effort was made to assure that the task force composition was representative of a broad range of interests. In the often vaguely defined areas of mental illness and health, this meant considering the opinions and concerns of practitioners of different disciplines and methods. In a training, research, and treatment center, this problem was in-

tensified. It was imperative that the different groups become identified with the Project if it were to get off the ground. The challenge was to engage the cooperation of various interested groups without becoming identified with any particular point of view such as the mutual concerns and suspicions of medical and non-medical practitioners or academically based and non-academically based practitioners regarding who would be most strategically involved in making key decisions.

Within a month of the Project's inception, letters describing the study were sent to more than 5,000 members of relevant professional groups. These letters, sent out over the signature of the Commissioner of Mental Health, also solicited comments and requests for further information. There was considerable response, and more than 1,000 copies of the *Plan for Planning* were sent out on requests.[6]

In addition, members of the staff met regularly with professional groups throughout the state to reassure them about the goals of the project and to ask their help.

These steps, together with the effort to include leaders of all segments of opinion on the task forces, helped to create a mutually cooperative attitude between the Project and the numerous interested professional groups.

Various professional associations were encouraged to develop standing committees on mental health to consider the emerging role of their discipline in the rapidly changing field of mental health, to concern themselves with the improvement of the total field of community mental health and to participate in an ongoing dialogue.

Meetings, sometimes extending over many months, occurred with representatives of organized medicine (the Massachusetts Medical Society, the American Academy of General Practice and the American Academy of Pediatrics), psychology and social work. Public presentations were scheduled at public health and public welfare meetings.

Relations with the Department of Mental Health

It was recognized early that the independent status of the Project might strain relationships with the Department staff and make it difficult for the Project to gain maximum benefit from the Department's experience and expertise. Since the Project's activities could be interpreted as a challenge to the competence of those involved in the ongoing program, it was decided that the responsibility for reaching out and maintaining liaison rested with the Project staff.

The Project Director met frequently with the Commissioner of Mental Health for consultation on policy. The Assistant Commissioner served in an official liaison capacity, regularly attending Project staff meetings. In addition, several key Department people participated regularly in staff meetings and minutes were widely distributed in the Department. On invitation of the Commissioner, Project members participated in staff meetings of the Department on a rotating basis. Regular consultation was held with the Department's research and operations personnel, and liberal use was made of their past experience in Massachusetts and of data regularly collected by them. Two specialists from the Department served as joint staff persons to a task force and more than 60 employees of the Department served, as individuals, on task forces.

In addition to these formal mechanisms, relations between the Project and the Department were enhanced by the long standing professional rapport existing among personnel of the two agencies.

During both years the planning staff met regularly with a variety of specialized groups within the Department. On a regular basis the Project staff was invited to meetings of the state hospitals and state school superintendents.

Staff meetings of the Divisions of Mental Hygiene and Legal Medicine also provided a basis for interaction. Special sessions, some conducted at Brandeis University, were also held with the Department's social workers, psychologists, nurses and occupational therapists. In addition, an opportunity was provided to meet with the trustees of state hospitals.

Relations with Communities

Another challenge involved relations with community groups throughout the state. The staff recognized that its lack of knowledge about the internal situations in the various communities would make it necessary to look to the established community channels for assistance if local communities were to be a part of the planning effort. Therefore, early in the fall of 1963, both lay and professional representatives of Chests and Councils throughout the state were invited to a meeting at a centrally located state hospital. The purpose of this meeting was to acquaint them with the nature of the Project and to obtain their cooperation. Their general response was, "Our communities are interested. What role can we play now?" Project staff indicated a willingness to meet with appropriate groups and leaders in any community to discuss a more specific role for their community.

As a result of this meeting and some energetic community organization work on the part of the Massachusetts Association for Mental Health (meetings were also held with their local executives and board leaders), invitations were extended for Project staff to meet with community groups throughout the state. In many areas, groups responded to a suggestion that local self-surveys would be useful. They were told the following:

- Consultation would be provided, but not staff services. An exception was the assignment of a student to work one day a week in one community.
- Surveys and community projects would be the responsibility and property of the local community. They were free to accept or reject any suggestions concerning method or specific subject matter to be studied, while the Project remained free to accept or reject community recommendations. Project staff would not become directly involved with internal decisions such as which agencies should be invited to sponsor the local study or which cities or towns should be included in the

[6] "Comprehensive Mental Health Planning in Massachusetts: An Operating Schedule—A Plan for Planning" (Massachusetts Mental Health Planning Project, mimeographed).

study area. Decisions of this nature were beyond the Project's scope of involvement. Project staff, however, was prepared to offer consultation on these matters.

- It would be advisable to use available local expertise in research and community organization.

Staff continued to meet with interested lay and professional groups throughout the state interpreting the Planning Project. Many groups, initially engaged in the self-study activity, also accepted responsibility for organizing public hearings in their area.

Various mental health associations, through their annual meetings and special meetings, offered a continual forum for the Planning Project staff. Participants in these sessions included board members and staff of the associations, staff members of various clinical facilities and interested citizens. Of special importance was the participation of many legislators and officials from local government. Collectively hundreds were reached in this manner.

Similarly, the Massachusetts State Labor Council, AFL-CIO sponsored an all day public meeting examining the role of organized labor in community mental health. This meeting represented the first of its type sponsored by organized labor.

The Advisory Council

Responsibility for approving the final report was assigned to a 67 member Advisory Council on Mental Health Planning appointed by the Governor. Each member served as an individual, not as an agency representative. The specific statement of responsibility as outlined in the Massachusetts Plan for Planning and accepted by the National Institute of Mental Health follows:

> "Under the chairmanship of the Commissioner of Mental Health, this group (the Advisory Council) will receive and review periodic reports from the Project staff. It will be the responsibility of the Advisory Council to receive, study, and either approve or revise the comprehensive plan for a mental health program submitted by the Project staff."

As conceived by the Massachusetts Mental Health Planning Project, the Advisory Council was to serve as a policy making and not an administrative body. Its services were focused primarily on the second year of the Planning Project during which time recommendations of the various task forces and study groups were submitted. Since minority views had been encouraged, it was assumed that conflicting recommendations would occur in certain areas. It was the function of the Advisory Council to mediate or arbitrate such disputes or, if it wished, to continue majority and minority views. Enough consensus had to be achieved to effectuate a reasonable plan.

Another function of the Advisory Council was the responsibility, with staff, to coordinate the various special reports.

A further responsibility was to make sure that the final report fairly represented the range of interests: the consumers, the public, the private practitioners, the voluntary organizations, the governmental organizations, and the executive and legislative branches of government.

A 10 member Steering Committee met regularly with the staff to develop operational procedures and to give special attention to the regionalization studies.

The complete list of members appears in Appendix A.

Publications

Throughout the life of the Project a number of publications and reports were prepared and circulated. Beginning with the original Plan for Planning, our operational plan, papers were prepared for professional journals and later reprinted and circulated. Smith, Kline and French published a feature story on the Project's activities which was distributed widely. The newsletters of the Massachusetts Mental Health Association, certain of the local mental health associations and the Department of Mental Health, among others, published regular stories of our activities. In addition the press and radio covered our activities on a continuing basis.

RELEVANT FACTS AND GENERAL CHARACTERISTICS

Meaningful plans for the development of future mental health services must be based upon factual data wherever available. Although other considerations such as political and financial stringencies will also play a major role, knowledge of pertinent information will still be necessary in rational program planning.

Factual data considered by the Planning Project in its deliberations included traditional indices such as population distribution and mental hospitalization rates, but also much broader demographic, ecological and social welfare indices. The inclusion of a wide variety of data was especially necessary for planning community mental health programs which direct their efforts toward total populations rather than individual patients. If planned mental health programs are to diversify their efforts beyond the treatment of acute and chronic illness and move into primary prevention, equal attention must be given to environmental and social data.

Data are presented in the four major categories of general characteristics of Massachusetts, population statistics and trends, indices of over-all community need and the extent of available resources.

These various data have been analyzed in relation to the Commonwealth's need for mental health services during the coming decade and form the basis for many of the Planning Project's recommendations.

General Characteristics

The historical traditions of Massachusetts and its diverse heritage scarcely need be outlined in this report. Perhaps of equal significance for capturing the current flavor of Massachusetts is an awareness of the growth and expansion which is transforming the Commonwealth into a state combining the best of the old and the new. This transformation is evident in the many facets of industrial expansion, highway building and urban renewal—all factors carrying major implications for the development of mental health programs and the provision of necessary services.

Although only the 45th largest state in the country, with a gross area of 8,093 square miles, Massachusetts ranked ninth in population in 1960 with 5,148,578 citizens. The state is divided politically into 14 counties which vary considerably in size and population. However, the counties currently have little governmental authority or function since these responsibilities reside either in the state or with the 39 cities and 312 towns of the Commonwealth. Consequently, in planning for mental health services it is not the formal county system which assumes importance, but rather the network of informal community liaisons which have developed throughout the state.

Topography

The topography of Massachusetts ranges from the rocky shores, sandy beaches and salt marshes of the eastern coast to the rolling hills, fertile valleys, and lofty mountains in the western part of the state. The provision of mental health services in eastern Massachusetts has not been seriously affected by the topography in contrast to mountainous Berkshire county which has remained relatively isolated and only recently is developing the necessary array of resources.

Economic Level

Currently, the state's economic level is healthy. After difficult periods following shifts in the textile industry, Massachusetts has successfully diversified to the point where it now depends less upon any single industry than all but three states. Attracted by the state's unsurpassed research facilities, new industries have been welcomed and the fields of electronic equipment, plastics and chemicals now play a leading role in maintaining the economy's vigor. Pockets of poverty do continue to exist, but as Table 1 attests, the economic level of Massachusetts residents is certainly above average and clearly in a position to financially support the expansion of critically needed mental health services.

Table 1

Income of Families, 1960*

Income	*Massachusetts*	*New England*	*United States*
Under $3,000	12.4%	13.6%	21.4%
$3,000-$5,999	34.2	34.8	32.8
$6,000-$9,999	36.4	35.3	30.8
$10,000 and over	17.0	16.3	15.1
Median income	$6,272	$6,128	$5,660

* Based upon 1960 federal census data.

The favorable socioeconomic level of the state is reflected in several related indices. Housing conditions are generally satisfactory, with 87% of living structures considered sound and only 13% rated as deteriorating or dilapidated. Among the nation's 11 leading industrial states, Massachusetts has the:

- Second highest proportion (12.8%) of its labor force in professional occupations in 1960.
- Second lowest rate of man days lost because of labor strikes during 1962.
- Second highest percent (80.9%) of its residents living in the same place as one year prior to the 1960 census.

Education

Since 1635, Massachusetts has been responsible for more firsts in the field of education than any other state in the nation. Education continues to be one of the Commonwealth's outstanding assets and its significance can be seen in our state's excellent reputation for medical and industrial research, insurance, investment banking, commerce and a highly technical industrial complex. The fact that some of the country's leading mental health training programs are located in Massachusetts has helped considerably in coping with manpower shortages.

There are 96 institutions of higher education in Massachusetts, including 14 which grant doctoral degrees. The general educational attainment of our citizens, as shown in Table 2, is above average.

Table 2

EDUCATION, 1960*

(Persons 25 years old and over)

Level	*Massachusetts*	*New England*	*United States*
Median Number School Years Completed	11.6	11.2	10.6
Completing High School or more	47.0%	44.6%	41.1%
Completing less than 5 grades	6.0%	5.9%	8.4%

* Based upon 1960 federal census data.

Almost 900,000 students are enrolled in public elementary schools in the state, with an average annual expenditure of $350 per child. There is an average ratio of one teacher for every 25 pupils.

TRANSPORTATION

Effective provision of community mental health services is, to a major extent, dependent upon the availability of accessible highways and public transportation. With increased planning emphasis being devoted to public transit systems as well as highway networks, all urban and rural residents will be able to reach the proposed mental health centers without undue difficulty. The existence of a major network of intrastate roads, the construction of such interstate expressways as routes 91, 93, 95 and 495, and the Massachusetts Turnpike have all served to sharply curtail the amount of time required to travel from one corner of the state to the other.

All planned local community mental health centers will be within 30 minutes travel time of their most distant boundaries. State hospitals which will provide continued treatment for those people requiring prolonged inpatient care, can be reached within one hour from all parts of their planned regions.

Population Statistics and Trends

The population growth, which is manifest throughout the nation, has certainly left its impact on Massachusetts. Consequently, population data must be carefully considered in the planning of new mental health centers. It makes little sense to plan for exactly equal or similar facilities in all parts of the state. An understanding of differential growth patterns is essential for determining the necessary size of local facilities.

A combination of increased life expectancy (67 years for men and 73 years for women) and the post-World War II baby boom has produced a 10% population increase in Massachusetts during each of the last two decades. From all indications, this rate of growth will continue and by 1980 our state's population will total approximately 6,260,000. An indication of the age distribution for the state's total population is seen in Table 3.

Table 3

MASSACHUSETTS POPULATION

Age (Years)	*Census*		*Projections**	
	1950	*1960*	*1970*	*1980*
Under 15	1,109,000	1,481,000	1,610,000	1,850,000
15-34	1,392,000	1,288,000	1,605,000	1,935,000
35-64	1,721,000	1,808,000	1,865,000	1,830,000
65 & over	468,000	572,000	620,000	645,000
Totals	4,690,000	5,149,000	5,700,000	6,260,000

* Adapted from projections made by the Massachusetts Department of Mental Health.

Analysis of the information in Table 3 highlights the fact that although our geriatric population will continue to grow, the segments of the population which will experience the greatest proportion of growth are those under 15 and between 15 and 34. Although the hospitalization rate for the groups under 34 is lower than that for the geriatric category, the sheer size of these groups plus their increasing use of outpatient services indicates that expanded mental health services are certainly necessary. Expansion of preventive services for the age group under 15 is especially urgent, if we are to attempt to reduce the hospitalization rates for older age groups. The total population and age composition for each planned mental health center area are presented in Appendix C.

Varying rates at which different parts of the state are growing can be seen in comparisons of county populations in 1950 and 1960 (Table 4).

Table 4

POPULATION BY COUNTIES

County	*1950*	*1960*	*% Increase*
Barnstable	46,805	70,286	50.2
Berkshire	132,966	142,135	6.9
Bristol	381,569	398,488	4.4
Dukes	5,633	5,829	3.5
Essex	522,384	568,831	8.9
Franklin	52,747	54,864	4.0
Hampden	367,971	429,353	16.7
Hampshire	87,594	103,229	17.8
Middlesex	1,064,569	1,238,742	16.4
Nantucket	3,484	3,559	2.2
Norfolk	392,308	510,256	30.1
Plymouth	189,468	248,449	31.1
Suffolk	896,615	791,329	—11.7
Worcester	546,401	583,228	6.7

Several statistics in Table 4 deserve special emphasis. Almost half of the state's total population in 1960 continued to live within the Boston standard metropolitan statistical area (SMSA). Although the population of Suffolk County decreased almost 12%

in the decade between 1950 and 1960, the major growth of surrounding counties like Essex, Middlesex, and Norfolk more than offset this isolated decrement. Other metropolitan areas experiencing major growth are Brockton, Lowell and Springfield. The New Bedford and Fall River metropolitan areas have remained stable and experienced virtually no population increase in the past decade.

Massachusetts continues to be a predominantly urban state, with 84% of its residents living within metropolitan areas and only 16% residing in rural areas. This proportion did not change in the decade between 1950 and 1960. With the increasing encroachment of metropolitan suburbs into the countryside the proportion of rural residents may decrease during the coming decades.

Indices of Community Need

The Planning Project adopted a broad outlook in trying to define relative overall community need for new mental health centers. Rather than restricting itself to a traditional index like mental hospitalization rates in each area as the measure of need, many other indices were also considered. Some of these were suggested in the 1965 National Institute of Mental Health *Guidelines for State Plans* and others were added when they seemed relevant. Data for every index were assembled on an area-by-area basis and used to determine each area's relative overall need.

Since 19 different indices were included, it was considered necessary to combine them into major categories. This was accomplished by correlating each index with every other index (Appendix D) and then extracting the four categories of socioeconomic indicators, mental and physical illness, social pathology and welfare indices.

Even these four categories are not completely independent as noted in Table 5. An area's number of welfare recipients is very significantly related to its socioeconomic condition. There is also a significant relationship between socioeconomic level and rate of social pathology. There is not, however, a significant relationship between an area's socioeconomic condition and its rate of mental and physical illness (as defined by our indices). Nor is there any significant relationship between the number of welfare recipents in a given area and that area's rate of mental and physical illness.

Table 5

Intercorrelations of Categories of Need

	Illness	*Soc. Path.*	*Welfare*
Socioeconomic Indicators	.22	.32	.63
Illness		.33	.20
Social Pathology			.69

d.f. = 35; $r_{.05}$ = .325; $r_{.01}$ = .42

Since social pathology problems are receiving increasing attention in mental health programs, it is vital to note that there is a significant relationship between social pathology and mental illness rates. The rate of social pathology in an area is most closely related to the number of welfare recipients in the area. Although the four categories of data being considered are to some degree interrelated, there is still sufficient variation between them to require that all be given consideration in the development of priorities for broad, multifaceted mental health programs.

The remainder of this discussion will present the findings regarding each category of need and indicate the relative standing of each planned mental health area in these categories. The relative nature of these data and those following later in describing resources must be highlighted. There is no implication of absolute deprivation or absolute sufficiency but merely that one community has more or less than another community.

Socioeconomic Indicators

To compute a measure which validly describes an area's socioeconomic level, attention must be paid to income, housing and educational standards. Data were collected for each of seven related indices. The statewide average for each of these indices is presented in Table 6, while Appendix E contains the relevant data for each of the 37 planned mental health areas.

Table 6

Massachusetts Socioeconomic Indicators, 1960*

Median income per family	$6,272
Number families having income less than $3,000	12.4%
Unemployment in civilian labor force	4.1%
Median value one-unit housing	$13,800
Percentage total housing units considered deteriorating or dilapidated	13%
Median years education completed by people over 25	11.6
Percentage of people over 25 with less than 5 years education	6%

* Based on federal census data.

In determining a local area's socioeconomic level, each of the seven indices was given equal weight. The local area's rank order on every index was then totaled to produce a measure of relative socioeconomic need. In Table 7 an average rank of 1 indicates that the Fall River area has very high need because its current socioeconomic condition is very low. Conversely, an average rank of 37 on Table 7 indicates that the Newton area has very low need because its current socioeconomic condition is relatively very high.

Table 7

RELATIVE SOCIOECONOMIC NEED

Area*	Average Rank	Area*	Average Rank
Barnstable	19.5	Lynn	27
Berkshire	16	Malden	24
Boston State	25	Massachusetts Mental	
Boston University	4	Health Center	29
Brockton	22	Medfield	31
Cambridge	26	Metropolitan	32
Concord	34	Mystic Valley	36
Danvers	28	New Bedford	2
Fall River	1	Newton	37
Fitchburg	13	Northampton	11
Foxborough	23	Plymouth	14
Franklin	12	Reading	35
Gardner	5	Southbridge	9
Government Center	8	South Shore	30
Grafton	15	Springfield	21
Haverhill	7	Taunton	6
Holyoke	17	Tufts	3
Lawrence	10	Westborough	33
Lowell	18	Worcester	19.5

* Specific cities and towns in each area are listed in the profiles later in this chapter.

MENTAL AND PHYSICAL ILLNESS

In considering an area's relative need for community mental health services, a central criterion must be the rate at which the area already uses such services. Although the present utilization rate is affected by factors such as the scope of existing resources, and local attitudes toward mental illness, it nevertheless does provide an estimate of current demand for service and at least an educated partial basis for future projections.

Three types of data were considered in computing each area's level of mental and physical illness and they will be discussed separately.

Mental Illness A comprehensive community mental health program will be directing its efforts toward the provision of a broad range of inpatient and outpatient services on both the direct and indirect levels. In projecting the need for such a program in a given area, planning should consider a variety of adjustment indices. There are extreme difficulties involved in assembling relevant data for every local area, and the only reliable statistic which could be used for priority purposes was the rate of admissions to mental hospitals during 1958-1961.[1] These data, on an area-by-area basis, are presented in Appendix F and include information on the number of admissions to state, private and Veterans Administration hospitals the ratio of state hospital-private hospital admissions and the total rate of admissions. The rank of 1 assigned the Tufts area indicates that it had the highest rate of total mental hospital admissions during the period studied. The Berkshire area's rank of 37 indicates that it had the lowest rate of admissions during this period.

Several additional findings, relevant to the state as a whole, require explication. The nationwide trend of a decreasing inpatient hospital census in the face of an increasing number of admissions exists in Massachusetts as well. During the fiscal year 1964, the number of resident patients in state hospitals decreased another 8%, from 18,474 at the start of the year to 17,062 at the end of the year. However, during the same period, 12,149 patients were admitted to state mental hospitals. This total was almost equally comprised of first admissions and patients who were being rehospitalized following discharge to the community.

The rising total number of first admissions is not due to increased rates of illness. Instead, it seems to be closely associated with the fact that during the past decade there has been a sharp rise in the population between ages 15-34, the age range during which many psychotic breakdowns occur. With the continuing population increase expected in this age range, the number of first admissions to mental hospitals may be expected to continue rising.

The number of readmissions which may be expected in future years is more uncertain. It is already evident that admission to a mental hospital no longer requires the extended inpatient care which was thought necessary only a few decades ago. A majority of those admitted are discharged within three months and only 10%-20% of first admissions are still inpatients a year after having been initially admitted. However, the rapid release of patients to the community has produced higher relapse rates and an increasing number of patients require periodic short-term care.

Development of adequate partial hospitalization services may represent an effective means for coping with the problems presented by seriously ill patients who require intensive services. Studies have already demonstrated that the number of inpatient admissions may be reduced by as much as 50% if a day hospital service is available. Similarly, the development of more adequate aftercare services for those discharged from a mental hospital may provide an effective alternative to readmission during times of crisis.

A potential network of resources for providing necessary community services to the adult mentally ill already exists in most of the 37 planned mental health areas. Resources such as family and social service agencies, private clinics, public health nurses and visiting nurses, private practitioners, and general practitioners represent valuable allies whose participation must be enlisted. In addition, the 36 local clinics operated by the Department of Mental Health are already providing an increasing amount of service to patients over 18 years of age. These clinics are truly moving toward the goal of becoming all-purpose community mental health centers as evidenced by the fact that during fiscal year 1964 they treated 3,521 adults, including 1,839 new admissions.

Statistical data regarding the mental health needs of children in each planned area were even more difficult to assemble than those for adults. The often cited figure that 10% of children require professional treatment could be utilized in planning, but the derivation of this estimate is certainly open to question. Professional services to children are provided under a wide variety of auspices, both psychiatrically and

[1] Based upon data obtained from the Massachusetts Department of Mental Health; T. Pugh and H. Wechsler, Department of Epidemiology, Harvard School of Public Health (Collected under NIMH Grant #MH 06599) and R. Notman, Mental Health Center Studies, Boston University.

nonpsychiatrically sponsored. Many problems remain untreated. These facts make it almost impossible to determine the prevalence of childhood emotional disturbance in any given area.

On a statewide basis, the 36 local clinics sponsored by the Department of Mental Health in 1964 provided outpatient service to 8,036 youngsters under 18 years of age. Of this total, 4,265 were new admissions while the remainder had been carried over from the previous year or were readmissions. Thousands of additional youngsters were treated by voluntary and private resources, thus emphasizing the continued need for major programs to serve this segment of our population.

An increasingly significant amount of service is being provided to emotionally disturbed children by the Division of Special Education of the Massachusetts Department of Education. As of April 1, 1965, a total of 463 children were receiving special education in public schools, 215 through special classes, 180 by home instruction, and 68 through integrated programs.

Many disturbed children are unable to tolerate even special public school programs. As of April 1, 1965, the Division of Special Education was financing the treatment of 175 youngsters placed in private day schools and 340 placed in residential treatment centers. More than 200 of the children requiring the latter type of care had to be placed in institutions outside of Massachusetts because of the critical shortage of appropriate facilities within the Commonwealth. Approximately 185 youngsters under 18 were treated in state operated facilities during 1964. At least triple that number could not be accepted because of the lack of space in the 80 bed Children's Unit at Metropolitan State Hospital and the 12 bed unit at the Massachusetts Mental Health Center.

Mental Retardation The second index to be considered in determining a local area's projected utilization of mental health services is the number of mentally retarded individuals living there. Although the retarded certainly require a wide variety of other community health and welfare services, the program of a mental health center is often crucial for certain diagnostic and treatment purposes.

Again, precise statistical data were lacking regarding the prevalence of mental retardation in the total population for each planned mental health area. Used instead were the data reported by the Division of Special Education of the Massachusetts Department of Education concerning the number of children enrolled in special classes for the retarded. Each local school system with at least five retarded youngsters is required by law to establish special classes for these children providing a fairly reliable estimate of the number of such children in each area.

During the 1963-64 school year, a statewide total of 11,626 children were enrolled in special classes for the retarded. The data in Appendix F indicate that the Boston University mental health area, which is ranked 1, had the highest rate of children enrolled in special classes. The Concord area, which is ranked 37, had the lowest rate.

Physically Handicapped A basic aspect of the community mental health concept is that programs should be directed towards high risk populations rather than towards only those individuals coming to the center's offices. The physically handicapped often encounter a variety of psychological problems as they try to cope with their disabilities and the services of a mental health center are valuable adjuncts in the total rehabilitation process. Since this population may create a significant demand for service in new centers, data on rates of physically handicapped were included in determining the level of need in each area.

Once again, accurate prevalence statistics were not available for the total population. Statistics reporting the number of children in special classes for the physically handicapped in each area were used instead. Data obtained from the Massachusetts Department of Education's Division of Special Education indicated that during 1963-64 a total of 35,965 children were enrolled in these special classes throughout the state. Rates for each planned mental health area are found in Appendix F. The Haverhill area, which is ranked 1, had the highest rate while the Lawrence area, which is ranked 37, had the lowest rate.

Over-all Index In summary, three different type of data were considered in calculating an area's level of mental and physical illness:

- Number of admissions to mental hospitals 1958-1961.
- Number of mentally retarded children in special classes.
- Number of physically handicapped children in special classes.

In constructing an over-all index for this category, the number of mental hospital admissions from an area was considered more significant for planning than the other two factors and was given a double weight. Table 8 indicates the relative rate of mental and physical illness in each of the 37 planned mental health areas. The Boston University mental health area, ranked 1, has the highest over-all rate of illness while the Reading area, ranked 37, has the lowest over-all rate of illness.

Table 8

RELATIVE RATE OF ILLNESS

Area	*Average Rank*	*Area*	*Average Rank*
Barnstable	10	Lynn	7
Berkshire	36	Malden	28
Boston State	31	Massachusetts Mental Health Center	30
Boston University	1	Medfield	19
Brockton	8	Metropolitan	5
Cambridge	9	Mystic Valley	32
Concord	34	New Bedford	12
Danvers	23	Newton	14
Fall River	26	Northampton	29
Fitchburg	13	Plymouth	18
Foxborough	25	Reading	37
Franklin	22	Southbridge	21
Gardner	2	South Shore	4
Government Center	27	Springfield	17
Grafton	24	Taunton	15
Haverhill	11	Tufts	3
Holyoke	35	Westborough	16
Lawrence	20	Worcester	6
Lowell	33		

Social Pathology

Mental health programs are being increasingly called upon to provide services to a wider variety of caseloads than was true several decades ago. As the programs of community mental health centers become integral components in the local network of total health and welfare services, problems of social pathology will assume increased importance. Rather than delimiting its focus to traditionally defined psychiatric illness, the mental health center will become a major resource in the community's effort to reduce social pathology. Even at this time, alcoholics constitute approximately 25% of all admissions to mental hospitals.

In defining the total need of a local area for mental health services, planning must consider the level of present social pathology. The four types of data available for this purpose and the statewide totals for Massachusetts are reported in Table 9.

Table 9

Social Pathology in Massachusetts*

	Number	*Rate*†
Total number of arrests by local and state police (1961)	248,022	4,825
Number of commitments to Youth Service Board facilities (1958-1963)	6,382	124
Number of arrests for drunkenness (1963)	61,641	1,199
Number of arrests for violation of Narcotics Law (1963)	360	7

* Based on data obtained from Massachusetts Department of Correction and Massachusetts Youth Service Board.
† Per 100,000 people.

Each of the four types of data was given equal weight in determining an area's over-all level of social pathology. The local area's rank on each measure (see Appendix G) was totaled to produce a total score. Table 10 indicates that the Boston University area, ranked 1, had the highest local rate of social pathology while the Medfield area, ranked 37, had the lowest rate.

Table 10

Relative Rate of Social Pathology

Area	*Average Rank*	*Area*	*Average Rank*
Barnstable	6	Lynn	10.5
Berkshire	20	Malden	21.5
Boston State	10.5	Massachusetts Mental Health Center	3
Boston University	1	Medfield	37
Brockton	16	Metropolitan	13
Cambridge	5	Mystic Valley	35
Concord	30.5	New Bedford	21.5
Danvers	26	Newton	34
Fall River	25	Northampton	28
Fitchburg	17	Plymouth	12
Foxborough	32	Reading	33
Franklin	23.5	Southbridge	14
Gardner	18.5	South Shore	27
Government Center	2	Springfield	7
Grafton	36	Taunton	30.5
Haverhill	15	Tufts	4
Holyoke	9	Westborough	29
Lawrence	23.5	Worcester	8
Lowell	18.5		

Welfare Indices

The number of welfare recipients in a given area will affect the nature of a local community mental health program in a variety of direct and indirect ways. In view of the inability of most welfare recipients to arrange for private treatment, it is the responsibility of publicly-supported programs to provide these individuals with necessary services. Rates of local welfare assistance are significantly correlated with the area's socioeconomic level. In areas with low socioeconomic level, extensive public mental health programs will be required.

Of additional significance to the mental health program is the fact that high welfare rates are significantly related to high rates of social pathology (Table 5). A mental health center located in an area of high welfare need should expect to direct a major segment of its resources toward social pathology as well as toward traditionally defined psychiatric illness.

Statewide recipients of five different types of public welfare are reported in Table 11.

Table 11

Welfare Recipients in Massachusetts*

	Number	*Rate*†
Old age assistance	55,323	1,076
Medical aid to the aged	25,165	490
Disability assistance	10,891	212
Aid to dependent children	62,611	1,218
General relief	15,514	302

* Based on October, 1963 report of Massachusetts Department of Public Welfare.
† Per 100,000 people.

Each of the five types of welfare data was given equal weight in determining the over-all level of welfare need. The local area's rank on each measure (Appendix H) was summed to produce a total score. Table 12 indicates that the Boston University area, ranked 1, had the highest local rate of welfare recipients while the Newton area, ranked 37 had the lowest rate.

Table 12

Relative Rate of Welfare Recipients

Area	*Average Rank*	*Area*	*Average Rank*
Barnstable	21	Lynn	7
Berkshire	15	Malden	8
Boston State	17	Massachusetts Mental Health Center	5
Boston University	1	Medfield	36
Brockton	20	Metropolitan	30
Cambridge	10	Mystic Valley	35
Concord	34	New Bedford	3
Danvers	27	Newton	37
Fall River	4	Northampton	31
Fitchburg	25	Plymouth	12
Foxborough	28	Reading	32.5
Franklin	16	Southbridge	18.5
Gardner	22	South Shore	29
Government Center	6	Springfield	18.5
Grafton	26	Taunton	23
Haverhill	9	Tufts	2
Holyoke	24	Westborough	32.5
Lawrence	13	Worcester	14
Lowell	11		

Over-all Community Need

Four major categories of data have now been analyzed in an attempt to define the relative need of each planned mental health area for comprehensive services. In considering the relevance of each category, it became necessary to decide whether certain categories were more significant than others in planning for future programs. Members of the Advisory Council's Steering Committee, as well as other knowledgeable individuals, indicated the following weighting for each category.

Category	*Weight*
Socioeconomic Indicators	3
Mental and Physical Illness	4
Social Pathology	4
Welfare Indices	3

Table 13 presents the relative rank of each local area in each category of need. Over-all total need was calculated by adding the weighted sums for each specific category and rank ordering these new totals. The Boston University mental health area has the highest total need (rank 1) while the Reading area has the lowest total need (rank 37).

However, a determination of over-all priorities must consider the extent of existing resources to cope with need in the local area.

Table 13

Rank on Each Category of Need and Total Need

Area	*Socio-Economic (Wt. 3)*	*Ill-ness (Wt. 4)*	*Social Pathology (Wt. 4)*	*Welfare (Wt. 3)*	*Total Need*
Barnstable	19.5	10	6	21	10
Berkshire	16	36	20	15	27
Boston State	25	31	10.5	17	22
Boston University	4	1	1	1	1
Brockton	22	8	16	20	14
Cambridge	26	9	5	10	8
Concord	34	34	30.5	34	35
Danvers	28	23	26	27	29
Fall River	1	26	25	4	13
Fitchburg	13	13	17	25	16.5
Foxborough	23	25	32	28	32
Franklin	12	22	23.5	16	20
Gardner	5	2	18.5	22	7
Government Center	8	27	2	6	6
Grafton	15	24	36	26	30
Haverhill	7	11	15	9	4
Holyoke	17	35	9	24	25
Lawrence	10	20	23.5	13	18
Lowell	18	33	18.5	11	23
Lynn	27	7	10.5	7	9
Malden	24	28	21.5	8	24
Massachusetts Mental Health Center	29	30	3	5	16.5
Medfield	31	19	37	36	34
Metropolitan	32	5	13	30	19
Mystic Valley	36	32	35	35	36
New Bedford	2	12	21.5	3	3
Newton	37	14	34	37	33
Northampton	11	29	28	31	28
Plymouth	14	18	12	12	11
Reading	35	37	33	32.5	37
Southbridge	9	21	14	18.5	15
South Shore	30	4	27	29	26
Springfield	21	17	7	18.5	12
Taunton	6	15	30.5	23	21
Tufts	3	3	4	2	2
Westborough	33	16	29	32.5	31
Worcester	19.5	6	8	14	5

Extent of Available Resources

Any evaluation of the extent to which available resources can cope with present and future mental health needs must remain a guess because of the complexities involved in such an assessment. A major obstacle is the current lack of agreement as to valid and reliable criteria of both mental health needs and program effectiveness. Lacking such criteria, the planning of services to meet local need must depend upon judicious evaluation of present program performance plus reasonable estimation of the potential in future developments.

Several types of information require consideration in assessing the ability of current resources to provide comprehensive services to the 37 planned mental health areas. Manpower figures, the services of private facilities and private practitioners and the scope of non-psychiatric resources in each area are all factors which will have a significant effect upon future program development.

Manpower

It has long been evident that the difficulty in attracting and retaining competent professional personnel is among the most vexing problems confronting program administrators. This difficulty is expected to continue during the foreseeable future and will place a major premium upon the imaginative deployment of scarce personnel. The constructive utilization of volunteers and semiprofessional people was pioneered in Massachusetts and has already led to similar developments throughout the rest of the country.

A statewide count of current manpower can only produce approximate totals. It is estimated that during 1964 the following numbers of personnel were employed in psychiatric settings throughout the Commonwealth:

Table 14

Mental Health Personnel, 1964*

Profession	*Number*
Psychiatrists	900
Psychiatric Residents	100
Psychologists (Ph.D.)	200
Psychologists (nonPh.D.)	200
Social Workers	1,500
Psychiatric Nurses	1,450
Licensed Practical Nurses	2,800
Psychiatric Attendants	4,900
Occupational Therapists	290
Recreational Counselors	65
Vocational Counselors	65
Special Education Teachers (including public schools)	1,000

* Estimates based upon data supplied by Department of Mental Health and professional organizations.

Although the number of personnel is inadequate for coping with the massive problems that confront us, Massachusetts must consider itself relatively fortunate when comparing itself to the rest of the nation (Table 15). The various university and professional training programs available in this state certainly play a major role in helping us to maintain this advantageous position.

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Table 15

PROFESSIONAL PERSONNEL INDICES, 1962*

Index	*Mass.*	*U.S.*
Physicians per 100 inpatients in state and county hospitals	1.27	.90
Professional personnel per 100 inpatients in public mental hospitals	7.90	4.50
Full-time employees per 100 inpatients in public mental hospitals	45.00	36.00
American Psychiatric Association members per 100,000 population	12.30	6.70
Professional hours in outpatient clinics per 100,000 population	424.00	174.00

* Based upon data in "Fifteen Indices" (1964 ed.).

The distribution of professional personnel within the state of Massachusetts is, at best, uneven. Significantly higher ratios of mental health professionals are available to residents in the metropolitan Boston area than to residents in other parts of the state. This is particularly true in regard to psychiatrists and psychologists. The Department of Mental Health, through its institutions, is the primary employer of psychiatric nurses and attendants and thus has been able to maintain a more even distribution of these types of personnel.

Private Practitioners In the long range planning of publicly supported mental health services, it is necessary to have accurate knowledge of the extent of service already available through private practitioners. There is no desire to establish public facilities which will duplicate or compete with the private practitioner. No systematic data existed regarding the contribution of the private practitioner. Early in 1964, the Planning Project undertook surveys to collect this information from psychiatrists and psychologists.

A further type of information which is of great significance in planning community programs is the experience of local physicians in evaluating and treating emotionally disturbed patients. Studies of these experiences were conducted in 1964 among pediatricians, general practitioners, and internists.

Private Psychiatric Services In cooperation with the Mental Health Committee of the Massachusetts Medical Society and the Northern New England District Branch of the American Psychiatric Association, a twenty-item questionnaire was mailed in February 1964 to 593 Massachusetts psychiatrists. Within two months 319 (54%) of those contacted returned the material. Seven out of every ten psychiatrists see patients privately. Of those who do engage in private practice, 88% are located in metropolitan Boston.

Neurotic and psychotic disorders, marital problems, and sex deviates are accepted for evaluation and treatment by 90% of private practitioners. However, one out of five psychiatrists will not accept drug addicts, alcoholics, adult sociopaths and delinquent adolescents. Further, almost 50% of private practitioners are reluctant to accept cases with mental retardation, acute and chronic brain syndromes and convulsive disorders.

Approximately 30 hours per week is devoted by the psychiatrist to his private practice. An average wait of 1.4 weeks is necessary before he can see a non-emergency patient for diagnostic evaluation. For "ongoing treatment," an average wait of 6.4 weeks is needed before a non-emergency patient can be picked up. Almost 80% of private practitioners see psychiatric "emergencies" the same day. A variety of other techniques are also utilized so that a patient in this condition is treated immediately.

During the month of January 1964 an average of eight *new* patients was seen by a psychiatrist in his private practice. During the same month he treated an average of 32 *different* patients in his private practice. Approximately 135 different patients were seen by each psychiatrist during the entire year of 1963.

Only 14% of the time spent in private practice by psychiatrists is devoted to youngsters 18 or under. The major bulk of time (86%) is spent with adults 19 and over. Private practitioners saw less than five children apiece (out of a total caseload of 32) during the month of January 1964.

Welfare patients are seen for diagnostic evaluation by only 40% of psychiatric private practitioners and for treatment by only 20%. However, during January 1964 even those practitioners seeing welfare patients performed only one diagnostic evaluation apiece and treated less than one welfare patient apiece.

Although the response rate to the questionnaire may have biased the findings, many implications can be drawn from the data gathered in this study. It is obvious that private psychiatrists already assume responsibility for the care of a major segment of the population in metropolitan Boston.

This segment can be expected to increase with rising income levels, increased insurance coverage and briefer treatment techniques.

Psychologists in Private Practice The Massachusetts Psychological Association participated with the Mental Health Planning Project in a survey of psychologists to determine the degree and types of services offered by them in private practice. Of those responding to the questionnaire, 107 (almost 30%) indicated that they devote an average of ten hours per week to their private practice.

A major portion of the psychologist's private practice is spent in work with psychoneurotic disorders, marital problems and adolescent behavior problems. More than 50% of psychologists will not routinely accept psychotics, acutely disturbed individuals, cases with neurological impairment and the mentally retarded.

The psychologist spends about 65% of his time in private practice providing treatment while the remaining 35% is used to conduct psychological test evaluations. In contrast to the psychiatrist, who uses only 14% of his time for work with youngsters 18 or under, 45% of the psychologist's time in private practice is devoted to the testing or treating of children and adolescents. Consequently, although psychologists only spend one third the amount of time per week in private practice that psychiatrists do, during January 1964 they treated the same number of children (6.3) that psychiatrists did. During all of

1963, each psychologist in private practice treated approximately 16 patients and saw 23 more patients apiece for psychological testing.

A non-emergency patient could be given an appointment by psychologists for a diagnostic evaluation within one and one-half weeks and could be accepted for ongoing treatment within three and one-half weeks. Consultation on these cases is obtained from a variety of sources; 70% using a psychiatrist, 50% a physician, 45% another psychologist and 25% a social worker.

Although there are very few psychologists in full-time private practice in Massachusetts, there are more than 150 psychologists who devote more than a day per week to seeing private patients and thus they make a significant contribution to the provision of necessary services in a community. In addition, more than 130 psychologists provide consultation on a private basis to various community resources and bolster the quality of their mental health services.

Roles of Local Physicians Studies of the experiences of local physicians in providing mental health services were conducted by the Planning Project in cooperation with the Massachusetts Society of Internal Medicine and the Massachusetts Chapters of the American Academy of Pediatrics and the American Academy of General Practice. Fifteen-item questionnaires were sent in March 1964 to the members of these groups and the forms were returned by almost 40% of the total membership.

The extent to which emotional disturbances are recognized and treated in medical practices will have a major impact upon the demands for service at a mental health center. It has long been recognized that the local physician serves in an initial screening role. Both general practitioners and internists indicated that almost 20% of the patients seen by them in March, 1964 had disorders that were primarily emotional in nature. An additional 25% of their patients that month had medical conditions complicated by significant emotional problems. Pediatricians considered only five percent of their patients to have primarily emotional difficulties and only 10% to have medical conditions complicated by emotional disturbance.

Internists and general practitioners treat about two-thirds and pediatricians about one-half of the patients in whom they detect disorders of a primarily emotional nature. About one-third of these cases are referred elsewhere by the pediatrician, and about one-fourth by the internist and general practitioner. When treatment is provided by the local physician himself, the treatment method considered most effective is a combination of drugs and interviews. Frequent interviews alone are also thought to be helpful but the use of drugs alone, or only occasional interviews, are not thought to be very helpful.

Referrals by physicians are most frequently made to private psychiatrists and mental health clinics. Adult patients are also referred to state and private mental hospitals, while pediatricians make a significant number of referrals to psychologists in private practice. Approximately 70% of local physicians approve the recommendation of the Joint Commission on Mental Illness and Health that competent non-medical persons participate more extensively in treatment of the mentally ill.

Present and possible future mental health roles of physicians were explored through several questions. At the present time, pediatricians focus their activities in the areas of prevention and diagnosis with relatively little time being devoted to treatment. Approximately 40% of pediatricians think that they are now greatly involved in prevention and diagnosis but only 15% get greatly involved in treatment.

Current mental health activities of general practitioners and internists are more focused in the areas of diagnosis and therapy with relatively less attention being directed toward prevention. Between one-third and one-half of general practitioners and internists are now greatly involved in diagnostic and therapeutic services but only one-fourth are greatly involved in prevention.

The ideal role of the local physician in mental health functions was thought to center around diagnostic and preventive activities, with less emphasis being placed upon therapy. Only 25% of pediatricians thought that ideally they should be greatly involved in treatment but 75% indicated that they should become greatly involved in prevention.

Almost all physicians (between 85% and 95% of the groups studied) indicated that they felt the need for an opportunity to discuss problems about specific patients with a mental health specialist. Approximately 75% to 80% of pediatricians and general practitioners, and 50% of internists, expressed a positive interest in postgraduate training in mental health subjects.

Information was also obtained about the attitudes of physicians toward the care of the mentally retarded. They were asked their view of the opinion that retarded children, especially those under six years of age, develop better at home than when hospitalized. The data cited in Table 16 indicate that pediatricians are most in agreement with the current thinking while internists are most equivocal about the present approach.

Table 16

RETARDED CHILDREN DEVELOP BETTER AT HOME

	Approve	*Disapprove*	*Undecided*
Pediatricians	74%	5%	21%
General Practitioners	45%	27%	28%
Internists	25%	7%	68%

Physicians were also asked their opinion of the view that it is best for the mother of a defective child to be separated from him immediately after birth. General practitioners and internists are still most in agreement with this viewpoint while a majority of pediatricians have foresaken this previously widespread belief (Table 17).

Table 17

DEFECTIVE CHILDREN SHOULD BE SEPARATED FROM MOTHER

	Approve	*Disapprove*	*Undecided*
Pediatricians	16%	55%	29%
General Practitioners	46%	26%	28%
Internists	42%	8%	50%

Data derived from these studies underscore the significant contributions of local physicians to the care of the mentally ill and highlight the necessity of considering their potential role in the planning of comprehensive programs. The finding that almost all physicians feel the need for some type of mental health consultation, and a majority of them are interested in postgraduate training, offers an opening for truly expanding the role of this resource.

LOCAL FACILITIES

Now that statewide data regarding the roles of private practitioners and physicians have been analyzed, it becomes necessary to consider the specific services available in each of the 37 planned mental health areas. Such individual analyses would make it possible to indicate whether or not an area has the necessary services for dealing with its over-all need.

The information necessary for such analyses was obtained from a variety of sources. Many areas undertook surveys of the resources available to their communities and tried to pinpoint existing strengths and weaknesses. Reports containing such information were submitted to the Planning Project by study groups in Lynn, Salem, Mystic Valley, Central Middlesex, South Shore, Worcester, Pittsfield and Barnstable. Recent reports were also available from such communities as Boston, Cambridge, Springfield and Greenfield.

A more comprehensive effort to obtain data for every single community was initiated by the Planning Project in February, 1965. National Institute of Mental Health inventory forms were sent to every facility which could be identified as having as its primary concern the care of the mentally ill under psychiatric supervision. Additional forms were sent to representatives in each of the 37 planned areas so data could be collected about other nonpsychiatrically supervised mental health facilities and auxiliary facilities. The completed inventories were all returned to the Planning Project by the end of March, 1965.

Using the various data collected for each area, it has been possible to construct a reasonably reliable profile depicting the extent to which necessary services are available in each area. The ratings of each area made by a group of experts are not an assessment of the adequacy or the quality of services provided to an area but rather an indication of the degree to which necessary resources exist relative to other areas. Ratings were based upon the relative availability of psychiatric facilities, social service agencies, and other resources necessary to provide the five elements of a comprehensive community mental health program. In rating the scope of an individual facility's program, major consideration was given to the size of the staff in relation to the size of the population served.

The following resource profile for each of the 37 areas indicates the degree to which facilities are now available to provide children and adults with each of the five essential services in a community mental health program. It was assumed that state hospitals could provide acute inpatient service to their own local area but only continuing, or chronic care, to neighboring areas.

Resource Profiles for the 37 Community Mental Health Areas

The following ratings have been made about the availability of resources to an area for each essential element of service in a comprehensive program:

0—No resources available.

1A—Limited general resources available.

1B—Resources provide service to restricted populations.

2—Major general resources available.

If a geographic area is rated as currently having no available resources (0), limited general resources (1A), or restricted resources (1B), it can be assumed that new or expanded resources are required to provide this element of service. If an area already has major general resources (2), these resources may or may not be adequate to meet an area's needs.

The ratings for each area are presented in the following profiles together with an indication of the specific agencies which are now providing services. Facilities to serve the mentally retarded are not considered in this analysis since they are the subject of a separate study by the Mental Retardation Planning Project.

HOW THE BOSTON PROFILES WERE DEVELOPED

Four separate community mental health areas are planned for the city of Boston and services are to be provided in each by these existing and planned centers: Boston State Hospital, Massachusetts Mental Health Center, Boston University Mental Health Center, and Tufts University Mental Health Center. A fifth facility at the Government Center will be physically located within Boston but will be directing the bulk of its services toward communities adjoining Boston on the north.

In considering the facilities available within each of Boston's four planned areas, the rich variety of publicly, voluntarily, and privately supported agencies whose services are provided to the entire city without any concern for geographic boundaries, is immediately impressive. The relative ease of traveling within this area via public or private transportation make these facilities truly available on a regional basis.

Data gathered from inventory forms and other sources indicate that in addition to the four major existing and planned mental health centers within Boston, there are almost 20 more psychiatric facilities and more than 120 auxiliary facilities which provide some type of mental health service. Consequently, in rating the availability of mental health services within a limited area of Boston, the numerous other resources which are available on a city-wide basis must also be included.

Community Mental Health Program Area and Cities and Towns in Each Area	Continuing Care Hospital	Inpatient		Outpatient		Emergency		Partial Hospitalization		Consultation and Education	
		Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults
BARNSTABLE Barnstable, Bourne, Brewster, Chatham, Dennis, Eastham, Falmouth, Harwich, Marion, Martha's Vineyard, Mashpee, Mattapoisett, Nantucket, Orleans, Provincetown, Sandwich, Truro, Wareham, Wellfleet, Yarmouth	Taunton State Hospital	1A	0	1A	1B	0	0	0	0	1A	0
BERKSHIRE Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mt. Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, W. Stockbridge, Williamstown, Windsor	Northampton State Hospital	0	1B	2	1A, 1B	0	0	0	0	1A	1A
BOSTON STATE Hyde Park, Roslindale, West Roxbury, Dorchester South, Dorchester Central (tracts T4A, T4B, T5A, T5B, T7B, T8A, T8B, T9, X1)	Boston State Hospital	1A	2	2	2	1A	2	1A	2	1A	1A
BOSTON UNIVERSITY South End (less tracts G1, G2, G3, G4), Back Bay (tracts J3, J4, K3, K5), Roxbury (less tracts S2, S4, S5, S6, V2), Dorchester North (less tract T1)	Boston State Hospital	1A	1A	2	2	1A	2	1A	1A	1A	1A
BROCKTON Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Halifax, Hanover, Hanson, Holbrook, Norwell, Rockland, Stoughton, West Bridgewater, Whitman	Foxborough State Hospital	1B	1B	2	1A, 1B	0	1B	0	1B	1A	1B
CAMBRIDGE Cambridge, Somerville	Metropolitan State Hospital	0	1A, 1B	2	2	0	1A, 1B	0	2	1A	1B
CONCORD Acton, Boxboro, Carlisle, Concord, Lincoln, Maynard, Stow	Metropolitan State Hospital	0	1B	1A	1A	0	0	0	1B	1A	0
DANVERS Beverly, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester, Marblehead, Middleton, Peabody, Rockport, Salem, Topsfield, Wenham	Danvers State Hospital	0	2	2	1A, 1B	0	2	0	0	1A	1A

0—No resources available.
1A—Limited general resources available.
1B—Resources provide service to restricted populations.
2—Major general resources available.

DESCRIPTION OF RESOURCES

The recent surge of citizen interest in this area to construct a comprehensive center is certainly necessary if present service gaps are to be filled. A limited range of outpatient service is provided to children by the newly opened Barnstable Child Guidance Clinic but no facilities now exist in the area to serve adults. Martha's Vineyard Clinic has served that island for several years and will continue to do so after a comprehensive center is established on the Cape.

Plans are now being developed for a major mental health center in Pittsfield. The major service gaps which this program will have to fill include inpatient, emergency, and day care units. Outpatient services are now provided by the Berkshire Psychiatric Clinics, social service agencies, the Austin Riggs Center, and the Alcoholism Clinic at Pittsfield General Hospital. The Northern Berkshire Child Guidance Center will continue as a valuable resource for North Adams and its surrounding towns.

Major services for adults are now provided in this area by Boston State Hospital and the various other facilities in Boston. With the planned reduction of its service area within the next few years, Boston State Hospital will be capable of providing adequate services to its limited population of 230,187 people. Children's services to this area are now provided by the recently established Dorchester Guidance Center and other Boston facilities.

Elements of service which require expansion include residential, emergency, and day care programs for children, and consultation programs to the areas for both children's and adults' facilities.

A variety of existing services in this area will be integrated into the major Boston University Mental Health Center, which is due to be opened by 1967. Psychiatric services are now provided to the residents of this area by the Psychiatry Services at Boston City Hospital and Boston University Medical Center. The Roxbury Court Clinic and the Boston City Hospital Alcoholism Clinic also represent major existing psychiatric resources.

Because of the great over-all need in this area, the Boston University Mental Health Center will be required to direct much of its services toward expansion of day care programs for children and adults, and toward consultation with the area's other mental health resources.

No major facility now exists in this area to provide comprehensive services. The Judge Stone Clinic, the Brockton Family Service, and the Massachusetts Society for the Prevention of Cruelty to Children provide the bulk of outpatient services to children and adults. Inpatient care and a variety of other adult services are available at the Veterans Administration Hospital to servicemen. The Brockton Alcoholism Clinic and the Stoughton District Court Clinic supply special clinical services.

All adult services require considerable expansion as well as residential and day care programs for children.

A variety of mental health services are provided to the residents of this area by local facilities as well as by the numerous agencies in Boston. Major outpatient services are available for children and adults through two social service agencies, the psychiatric programs at Mount Auburn Hospital and Cambridge City Hospital, the Cambridge Guidance Center, and Cambridge Day Center. Specialized services are available from the Cambridge Court Clinic and the Cambridge Alcoholism Clinic. Psychiatric services at Harvard and Massachusetts Institute of Technology look after the needs of their student bodies.

The development of a comprehensive program in the Cambridge area will require the active coordination of existing facilities as well as the establishment of new ones.

Outpatient services of a limited nature are available to the residents of this area from the Waltham Clinic and the Concord Family Service. Valleyhead Hospital, which is privately operated, offers inpatient services to those seeking private care.

The provision of a comprehensive program to the residents of this area will require the expansion of existing outpatient facilities and the development of new inpatient, emergency, and day care programs for children and adults.

Mental health services to these North Shore communities are provided by Danvers State Hospital, the North Shore Guidance Center, and the Alcoholism Clinic at Salem Hospital. Several social service agencies also serve the area and offer extensive outpatient casework.

The geographic area to be served by Danvers State Hospital will be considerably reduced with the development of new resources for Essex County and should then be able to successfully expand its outpatient and day care programs.

Community Mental Health Program Area and Cities and Towns in Each Area	Continuing Hospital Care	Inpatient		Outpatient		Emergency		Partial Hospitalization		Consultation and Education	
		Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults
FALL RIVER Fall River, Freetown, Somerset, Swansea, Westport	Taunton State Hospital	1A	0	2	2	0	0	0	2	1A	1A
FITCHBURG Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Groton, Harvard, Lancaster, Leominster, Littleton, Lunenburg, Pepperell, Shirley, Sterling, Townsend, Westminster	Gardner State Hospital	1B	0	2	1A, 1B	0	0	0	0	1A	0
FOXBOROUGH Attleboro, Foxborough, Mansfield, North Attleboro, Norton	Foxborough State Hospital	0	2	1A	2	0	2	0	1B	1A	1A
FRANKLIN Ashfield, Bernardston, Buckland, Charlmont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Rowe, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, Whately	Northampton State Hospital	0	1A	1A	0	0	1A	0	0	1A	0
GARDNER Athol, Gardner, Hubbardston, Petersham, Phillipston, Royalston, Templeton, Winchendon	Gardner State Hospital	0	2	0	0	0	2	0	0	0	1A
GOVERNMENT CENTER Charlestown, Chelsea, East Boston, North End, Revere, West End, Winthrop	Danvers State Hospital	1A	1A	2	2	1A	2	1A	1A	1A	1A
GRAFTON Bellingham, Blackstone, Douglas, Grafton, Hopedale, Mendon, Milford, Millbury, Millville, Northbridge, Sutton, Uxbridge, Upton	Grafton State Hospital	0	2	0	0	0	2	0	0	0	1A
HAVERHILL Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury, West Newbury	Danvers State Hospital	0	1B	1A	1A, 1B	0	0	0	0	1A	0
HOLYOKE Belchertown, Chicopee, Easthampton, Granby, Holyoke, South Hadley, Southampton	Northampton State Hospital	0	0	2	2	1A	1A	0	0	1A	1A

0—No resources available.
1A—Limited general resources available.
1B—Resources provide service to restricted populations.
2—Major general resources available.

A major new center is now being constructed in Fall River by the Department of Mental Health and it will serve as the focal point for a comprehensive program. That such a center is necessary can be seen in the fact that no inpatient or emergency facilities exist for adults and only limited resources are now available to serve children. Existing services at Bristol County and Union Hospital Mental Health Clinics and at the Family Service Association should greatly benefit from the construction of the new center.

The North Central Mental Health Center, together with several social service agencies in the area, provides major services to children and more limited ones to adults. The Psychiatric Clinic at Burbank Hospital treats alcoholics and patients referred from Gardner State Hospital.

The provision of comprehensive services in the area will require the expansion of outpatient services and the establishment of new inpatient, emergency, and day care programs for children and adults.

The major elements of a comprehensive program for adults are available from Foxborough State Hospital and the Fuller Sanatorium. Services to children are much more restricted, with only the Attleboro Mental Health Clinic providing a limited program for children.

The Franklin County Mental Health Center, Franklin County Public Hospital, and the Greenfield office of Massachusetts Society for the Prevention of Cruelty to Children represent the major resources available in this area. Only limited outpatient services for children and limited inpatient and emergency services for adults are now provided.

Franklin County Public Hospital is considering the expansion of its psychiatric unit to supply some of the many other services necessary for a comprehensive program in Franklin County.

Reduction of the geographic area served by Gardner State Hospital through new regional programs will permit it to devote more of its resources toward the developmentof a comprehensive program in the Gardner area. No other mental health facilities exist in this area and the state hospital will be called upon to assume considerable responsibility. New facilities are urgently needed to treat emotionally disturbed children.

The major mental health center now being constructed as part of the Government Center complex should adequately complement those services now available from existing resources and provide this area with a truly comprehensive program.

Various psychiatric units at Massachusetts General Hospital and the North Suffolk Mental Health Center represent key community resources which, together with many other Boston facilities, already provide significant services.

Within the next few years new facilities will be established in Boston and residents of that area will no longer be sent to Grafton State Hospital. This change will produce an almost 50% reduction in the number of admissions to this hospital and thus permit it to redeploy its resources toward the provision of a comprehensive program for Grafton area residents.

Such a change is urgently needed since the state hospital is the only mental health facility in this entire area. No local services are currently available to children and such a program deserves high priority in the area's total plans.

A very limited range of services is now available to residents of this area because of the dearth of mental health facilities. The Northeastern Essex Mental Health Center and the Children's Aid and Family Service provide outpatient services to children and adults but no resources exist for emergency care, partial hospitalization services, and consultation. The privately sponsored Baldpate Hospital offers inpatient care but its beds are filled with patients from many other areas as well.

A new mental health center is necessary to fill the many existing gaps in a comprehensive program.

Major outpatient services are now provided to the area's children and adults by the Holyoke-Chicopee Mental Health Center and by the Holyoke social service agencies. However, no inpatient or day care program is now available in this area. The development of a comprehensive program requires the filling of these gaps and the expansion of emergency and consultation services.

Community Mental Health Program Area and Cities and Towns in Each Area	Continuing Care Hospital	Inpatient		Outpatient		Emergency		Partial Hospitalization		Consultation and Education	
		Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults
LAWRENCE Andover, Lawrence, Methuen, North Andover	Tewksbury Hospital	0	1A	2	2	0	1A	0	0	1A	1A
LOWELL Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsborough, Westford, Wilmington	Tewksbury Hospital	0	0	1A	1A, 1B	0	0	0	0	1A	1B
LYNN Lynn, Lynnfield, Nahant, Saugus, Swampscott	Danvers State Hospital	0	0	2	1A	0	0	0	0	1A	0
MALDEN Everett, Malden, Medford	Metropolitan State Hospital	0	0	0	1A, 1B	0	0	0	0	0	0
MASSACHUSETTS MENTAL HEALTH CENTER Brighton, Brookline, Jamaica Plain, Back Bay (tracts K4A, K4B, J5, S1) Roxbury (tracts S2, S4, S5, S6, V2)	Boston State Hospital	1A	2	2	2	2	2	1A	2	1A	1A
MEDFIELD Canton, Dedham, Franklin, Medfield, Medway, Needham, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham	Medfield State Hospital	1A	2	1A	2	0	2	0	1A, 1B	1A	0
METROPOLITAN Belmont, Waltham, Watertown	Metropolitan State Hospital	1A	2	2	2	1A	2	1A	1A, 1B	1A	1A, 1B
MYSTIC VALLEY Arlington, Bedford, Burlington, Lexington, Winchester, Woburn	Metropolitan State Hospital	0	1B	2	1A, 1B	0	0	0	1B	1A	1B
NEW BEDFORD Acushnet, Dartmouth, Fairhaven, Gosnold, New Bedford, Rochester	Taunton State Hospital	0	0	1A	1A, 1B	0	0	0	0	1A	1B

0—No resources available.
1A—Limited general resources available.
1B—Resources provide service to restricted populations.
2—Major general resources available.

DESCRIPTION OF RESOURCES

Many of the resources necessary for a comprehensive program already exist in Lawrence. The Greater Lawrence Guidance Center together with four social service agencies and local offices of the Massachusetts Rehabilitation Commission and the Division of Child Guardianship provide major outpatient services for children and adults. Inpatient services are available at Lawrence General Hospital.

Expanded inpatient services for adults, residential facilities for children, and emergency and day care services for children and adults are still required in this area.

A new mental health center is currently under construction in Lowell and it will provide a wide range of services to children and adults. That such a center is necessary can be seen from the fact that the only existing resources are the Mental Health Clinics, which provide limited outpatient care to children and adults, the Alcoholism Clinic at Lowell General Hospital, and the Veterans Administration Clinic which restricts its services to veterans.

The new facility being established by the Department of Mental Health is intended to provide a comprehensive program.

No psychiatric facility exists in this area to provide any of the essential services to an adult population. Several social service agencies do provide outpatient services but the lack of psychiatric consultation and referral sources certainly has a hindering effect.

The Child Guidance Center of Lynn provides outpatient and consultation services for children, and represents an existing facility through which to develop a comprehensive program for both children and adults.

Residents of the Malden area must obtain the bulk of their mental health services in other communities since almost no agencies exist in their own area. The Family Service Agency of Malden and the Malden Court Clinic provide services which are far from adequate for meeting the area's needs.

A comprehensive program will require the development of a variety of virtually new services.

Major services for adults and children will be provided to this area by the Massachusetts Mental Health Center. Although now a facility which accepts patients from the entire state, the Massachusetts Mental Health Center will accept responsibility for comprehensive services in its ownarea, with the initiation of regional programs.

Other existing psychiatric facilities in this area include the Brookline Mental Health Clinic, the Brookline Court Clinic, and the Brigham Alcoholism Clinic.

Major services for the adult residents of this area are available through Medfield State Hospital and Westwood Lodge. Limited children's services are provided by the Norfolk Guidance Center and they will require expansion. The lack of adequate social service agency programs has placed an added responsibility upon the psychiatric facilities in this area.

With the reduction of the geographic region for which Medfield State Hospital will provide acute inpatient care, this facility will be able to considerably expand its services in the local Medfield-Norwood area.

Residents of this area obtain mental health services from local facilities as well as from the resources located in Boston. Metropolitan State Hospital will become an even more central resource after the regionalization program has reduced its geographic base to this particular area. Other significant resources include McLean Hospital, the Beaverbrook Guidance Center and two family service agencies. Special services are provided by the Waltham Court Clinic.

Again, the development of a comprehensive program for this area is as much dependent upon the coordination of existing facilities as upon the establishment of new ones.

Although the relative overall need of this area is quite low, its sophisticated approach to the use of mental health services has placed a heavy demand upon the existing agencies. Outpatient and consultation services are provided for children by the Mystic Valley Children's Clinic while several social service agencies in this and neighboring areas provide extensive casework for adults. The Bedford Veterans Administration Hospital offers a variety of services to veterans.

A comprehensive program will require the expansion of all types of adult services and the development of residential and day care services for children.

Only limited outpatient services are available for children and adults in this area from a variety of psychiatric clinics and social service agencies. No inpatient, emergency, or day care facilities are provided within the area and these elements of service must be established if a comprehensive program is to be available in New Bedford.

Community Mental Health Program Area and Cities and Towns in Each Area	Continuing Care Hospital	Inpatient		Outpatient		Emergency		Partial Hospitalization		Consultation and Education	
		Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults
NEWTON Newton, Wellesley, Weston	Medfield State Hospital	0	1B	2	1A	0	1A	0	0	1A	1A
NORTHAMPTON Amherst, Chesterfield, Cummington, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, Worthington	Northampton State Hospital	0	2	1A	1B	0	2	0	1B	0	1A, 1B
PLYMOUTH Carver, Duxbury, Kingston, Marshfield, Pembroke, Plymouth, Plympton	Taunton State Hospital	0	0	0	0	0	0	0	0	0	0
READING Melrose, North Reading, Reading, Stoneham, Wakefield	Danvers State Hospital	0	0	1A	0	0	0	0	0	1A	0
SOUTHBRIDGE Brimfield, Brookfield, Charlton, Dudley, East Brookfield, Holland, Monson, North Brookfield, Oxford, Palmer, Southbridge, Spencer, Sturbridge, Wales, Ware, Warren, Webster, West Brookfield	Worcester State Hospital	0	0	0	0	0	0	0	0	0	0
SOUTH SHORE Braintree, Cohasset, Hingham, Hull, Milton, Quincy, Randolph, Scituate, Weymouth	Medfield State Hospital	0	1A	2	2	0	0	0	0	2	1B
SPRINGFIELD Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Longmeadow, Ludlow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, Wilbraham	Northampton State Hospital	1A	1A	1A	1A, 1B	0	0	0	1A	1A	0
TAUNTON Berkley, Dighton, Lakeville, Middleboro, Raynham, Rehoboth, Seekonk, Taunton	Taunton State Hospital	0	2	1A	2	0	2	0	2	0	1A
TUFTS South End (tracts G1, G2, G3, G4) South Boston, Dorchester North (tract T1)	Boston State Hospital	1A	1A	2	2	1A	2	1A	0	1A	1A
WESTBOROUGH Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Millis, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough	Westborough State Hospital	1B	2	2	2	0	2	0	2	2	1A, 1B
WORCESTER Auburn, Barre, Boylston, Hardwick, Holden, Leicester, New Braintree, Oakam, Paxton, Princeton, Rutland, Shrewsbury, West Boylston, Worcester	Worcester State Hospital	1A	2	2	2	0	2	0	2	2	2

0—No resources available.
1A—Limited general resources available.
1B—Resources provide service to restricted populations.
2—Major general resources available.

DESCRIPTION OF RESOURCES

A rather limited range of facilities is physically located in the Newton area but the residents of these communities make extensive use of Boston resources. The Newton-Wellesley Hospital's Psychiatric Clinic, the Wellesley Human Relations Service, and the Region West Family Counseling Service represent major resources in the area. Privately operated Wiswall Hospital also provides inpatient and outpatient services.

All types of adult services require expansion as well as residential and day care programs for children.

Northampton State Hospital, which now serves all of western Massachusetts, will have its geographic service base considerably reduced with the introduction of new programs. It will then be able to develop a comprehensive program for the local Northampton area in conjunction with existing social service agencies and clinics at the University of Massachusetts. The Northampton Veterans Administration Hospital provides inpatient and outpatient services to veterans.

Expanded local services for children require a high priority in future planning.

The residents of this area are totally dependent upon facilities in other regions. Not a single facility is located in Plymouth to provide mental health services to children or adults. Obviously this area must rank among those having the highest priority in the development of new facilities.

The Eastern Middlesex Guidance Center is the only existing mental health facility in this area. It provides outpatient and consultation services for children but does not currently accept adults. This existing facility might well serve as the core about which to develop an expanded comprehensive program serving both children and adults.

This area must rank among those having the highest priority in the development of new programs. Not a single mental health facility currently exists in this area and its residents are dependent upon the services of Worcester and Springfield resources. Comprehensive services for children and adults are an urgent necessity.

Major outpatient services to children and adults are provided by the South Shore Mental Health Center and several social service agencies located in Quincy. Special services are also available at the Quincy Alcoholism Clinic and at the Quincy Court Clinic.

The South Shore Mental Health Center has initiated planning for a major center in Quincy. Service gaps requiring new resources include inpatient, emergency, and partial hospitalization programs for both children and adults.

Only a limited range of services is now available in what is the largest planned mental health area in the state. The basic elements of a comprehensive program are provided by several psychiatric and social service agencies but they require coordination and expansion. Inpatient services are now available for adults at Springfield General Hospital but a much larger program is necessary to meet the total needs of the area.

The population growth of this part of the state will require that the Westfield area ultimately develop its own comprehensive program.

With the reduction of the geographic region to which Taunton State Hospital now provides adult services, it will be possible for this facility to become a center for comprehensive services in its local area. Other mental health services are provided in the Taunton area by the Massachusetts Society for the Prevention of Cruelty to Children and Family Counseling but an expanded program for children is urgently needed.

An expanded range of mental health services will be provided to this high-need area by the planned Tufts-New England Center Hospital program. Particular emphasis will be necessary upon partial hospitalization and consultation programs.

Services are already provided to this specific area by the Special Study Unit at Boston Dispensary, the Child Guidance Clinic at Boston Floating, and the Psychiatric Service at New England Center Hospital.

This area is one of the most rapidly growing in the entire state. The core of a comprehensive program already exists in the services provided by Westborough State Hospital and the Framingham Mental Health Center. The services of these facilities, in addition to those of the social service agencies, and the Framingham Court Clinic, require coordination before expansion is undertaken. Geriatric services are provided by Cushing Hospital.

A rich variety of resources exists in this area and the development of a comprehensive program for Worcester area residents is highly dependent upon the coordination of these services. Worcester State Hospital and the Psychiatric Unit at St. Vincent's Hospital provide major adult programs as do a variety of social service agencies. Children have long been treated at the Worcester Youth Guidance Center and other local facilities. The Alcoholism Clinic at St. Vincent's and the Worcester Central District Court Clinic provide specialized clinical services.

The establishment of the state medical school in Worcester should allow this area to develop a truly outstanding program.

Priorities in Program Development

Preceding sections of this chapter have presented detailed findings about the overall need of each planned mental health area as well as a profile of its existing resources. This information can be combined to determine which areas have relatively high priority and which have low priority. However, there are other factors that cannot be given adequate consideration in this type of working system such as the urgent need for special services to specific groups like children, the readiness of communities to proceed, the availability of matching funds and the importance of giving special emphasis to teaching institutions in order to enlarge the manpower base. These other factors should also be considered in the implementation of final plans.

The 37 planned areas of the state have been divided into three groups of high, medium, and low overall need (Table 18). The high group includes those geographic areas having the relatively greatest socioeconomic need and pathology (Table 13) while the low group includes those areas having the least such need and pathology. There is far greater variability between areas in different groups than between areas within the same group.

On the basis of the distribution of existing resources for community mental health programs, the 37 areas of the state have been rated as having available limited, average, or major resources.

Table 18 indicates that those geographic areas having high overall need and limited available resources require the greatest priority in developing new or expanded resources. Those areas having low overall need and major available resources should receive the lowest priority in developing new resources.

The Advisory Council urges most strongly that the Department of Mental Health assume active responsibility for helping areas with high priority develop the necessary services.

Table 18

AREA PRIORITIES IN PROGRAM DEVELOPMENT

Resources

OVERALL NEED	*Limited (11)*	*Average (14)*	*Major (12)*
High (13)	Barnstable Haverhill Lynn New Bedford Plymouth Springfield	Fall River Gardner	Boston University Cambridge Government Center Tufts Worcester
Medium (12)	Franklin Lowell Malden Southbridge	Brockton Fitchburg Holyoke Lawrence	Boston State Massachusetts Mental Health Center Metropolitan Taunton
Low (12)	Reading	Berkshire Concord Danvers Grafton Mystic Valley Newton Northampton South Shore	Foxborough Medfield Westborough

COMMUNITY MENTAL HEALTH PROGRAMS

Key Recommendations

1. A community mental health program should accept as its goal the responsibility for helping those of all ages and diagnostic categories wherever problems arise in the community. Responsibility should be assumed for populations which are especially vulnerable to emotional disturbance.

2. Any program making use of public funds should not establish arbitrary service criteria such as age, financial ability, race or religion, or residential requirements. Services must be made available to all.

3. To ensure that services are accessible at the local level, comprehensive programs should serve populations of approximately 75,000 to 200,000 people.

4. To be comprehensive a community mental health program must provide at least five essential elements: inpatient services, outpatient services, partial hospitalization services, emergency services, and consultation and education services.

5. When two or more facilities participate in a comprehensive program, continuity of service to patients must be maintained.

Formal arrangements must be made between the facilities so that a patient eligible for treatment in one resource can also be treated in the second, if it seems clinically indicated.

6. The precise manner in which a community's publicly and privately supported agencies coordinate their services to make up the comprehensive program should be determined at the local level in accordance with standards established by the Massachusetts Department of Mental Health.

7. A local program's director should be selected and hired during the earliest phase of planning.

8. Mental health professionals should be responsible for providing consultation, training and additional types of support to welfare departments, settlement houses, public health nursing associations and other agencies providing a variety of mental health services in lower socioeconomic areas.

9. The facilities of general hospitals should be made available for psychiatric patients.

10. The Department of Mental Health should equitably reimburse the general hospital for care provided to medically indigent local citizens on a fee-for-service contract basis or through loaned personnel.

11. Private practitioners should be permitted to hospitalize and treat their patients in state-supported facilities when clinically indicated.

12. In order that financial considerations do not impede the patient's treatment program, state reimbursement for professional services provided to inpatients in a general hospital should be made on a flat per diem basis rather than by specific type of service rendered.

13. Existing state mental hospitals should provide two distinct purposes: the five essential services of a comprehensive program to the geographic area in which it is located and continued treatment facilities for its own local area as well as for neighboring community mental health programs.

14. Existing state mental hygiene clinics should be integrated into community programs.

Options could include expanding services to provide a comprehensive program to its entire area, coordinating the program with the neighboring mental hospital under a single administrator, or providing a range of services to only a limited part of the service area.

15. Voluntary community agencies and clinics should be encouraged to become integral components of a comprehensive program under a variety of administrative options.

16. Regional administrative positions to provide direction and liaison between the Central Office of the Department of Mental Health and its local facilities should be established by the Department.

17. Active citizen participation in the planning and operation of the local center should be ensured through a formal administrative structure.

A major goal of the Planning Project was the development of a comprehensive plan through which all of the Commonwealth's publicly-supported mental health services could assume a community orientation. Such programs will not be entirely new by any means since the concept of community mental health may truly be said to have undergone much of its theoretical gestation and experimental development in this state.

In spite of this history and the widespread support which is now being evinced for community mental health programs, it is important to realize that these programs still represent different things to different people. To some, the essence of a community mental health service is its physical location in the midst of a population center, thus permitting utilization of such facilities as the general hospital. To others, the distinguishing feature of a community mental health program is its active cooperation and participation with all segments of the community's health and welfare system. To still others, the essential fact is that a local citizen group assumes responsibility for program planning and development.

Essential Elements

Differences will continue to exist, perhaps justifiably, about the central emphasis and precise functions of a community mental health program. However, there is current agreement that the following elements must be included in the framework of any program:

- The patient must be the focus of a multifaceted program designed to meet his current needs. Patients should not be fitted into an institution's administrative needs.
- The program must be comprehensive. It should include inpatient, outpatient, emergency and partial-hospitalization services and education and consultation services. A program must serve all age groups.
- The purpose of mental health intervention should aim to return the patient to his ordinary life situation as soon as possible. It should rarely be the goal of psychiatric intervention to remake the patient into a new person.
- Mental health programs should move the patient through a variety of treatment stages as rapidly as possible until he is returned to the community. Perhaps, the harm caused by separation from the community and by the promotion of dependency and regression can be prevented in this manner.
- Continuity of therapeutic relationship should be provided from the beginning to the end of intervention. Private practitioners have long adhered to this principle and it must be incorporated into institutional practice as well.
- Active communication must be maintained among all levels of the program.

A New Orientation

Many crucial implications stem from future changes in practice and priorities. All appropriately trained personnel must be used in an optimum fashion and a fresh analysis of job descriptions is vital. All mental health professionals will be required to function in new ways. Currently defined areas of interest will be broadened and a redefinition of the particular prerogatives now assumed by psychiatrists, psychologists, social workers and nurses can be expected. Individual competence rather than disciplinary prerogative must become the criterion used to define functions.

In developing necessary programs, the community mental health professional accepts responsibility for helping those of all ages and diagnostic categories wherever problems arise in the community. He does not wait for patients to come to his office. Professionals participating in community mental health programs (including psychiatrists, psychologists, social workers and nurses) will differ from traditional colleagues in providing direct and indirect service, to large numbers of people with whom they have no personal contact. The new programs will not be able to wait for patients to come to them since responsibility is assumed for especially vunerable populations and not only for individual patients.

Such an ambitious program cannot be undertaken by the mental health center alone, certainly not upon the traditional basis of diagnosis and treatment of individuals. The use of complementary resources in the health and welfare system will be imperative. Mental health professionals must utilize other resources not as a second best choice but rather out of sincere recognition that the mental health center is just one of the appropriate resources in the community. In addition to using a direct approach to patients, mental health specialists will also utilize indirect methods such as consultation to foster and support the contributions of other caregiving resources.

The Program's Functional Components

Two basic questions must be resolved for effective development and operation of a community mental health program. For whom are services to be provided? What range of services will the mental health facility provide?

Considerable deliberation about these questions led to the conclusion that there is no single correct answer. Instead, various combinations will be applicable to different communities depending upon the unique factors present in each of them.

For Whom are Services to be Provided?

Any program making use of public funds cannot establish arbitrary service criteria such as minimum or maximum age, financial ability, race or religion, diagnosis or minimum residential requirements. Services must be available to all.

A related aspect of this first question is the problem of how to define the character and size of the community to be served by a specific mental health program. The Planning Project has used the guideline of the National Institute of Mental Health that accessibility of services be ensured by having each facility, with some exceptions, serve a population of not less than 75,000 and not more than 200,000 persons. A fuller description of the areas developed for this purpose will be found in the section on regionalization.

What Services are to be Provided?

For a program to be considered comprehensive it must include the five essential elements described in the federal regulations for community mental health centers.

- Inpatient services.
- Outpatient services.
- Partial hospitalization services, including at least day care services.
- Emergency services provided 24 hours per day must be available within at least one of the three services just cited.
- Consultation and education services available to community agencies and professional personnel.

Federal regulations indicate that for an adequate range of services to be available to the community, an additional five elements should be included.

- Diagnostic services.
- Rehabilitative services, including vocational and educational programs.
- Precare and aftercare services in the community, including foster home placement, home visiting and halfway houses.
- Training.
- Research and evaluation.

One of the most important reasons for including these ten elements in a comprehensive program is to insure continuity of services to patients. A basic tenet which must be adhered to is that a person eligible for treatment in any one element of service will also be eligible for treatment within any other service element. Effective treatment must not be impeded by arbitrary administrative regulations which run contrary to clinical needs.

In many communities it will not be feasible or appropriate for a single facility to provide all of the ten elements in a comprehensive program by itself. It may be much more practical for a number of existing, and possibly new, agencies to coordinate their programs in such a manner as to provide a complete range of services. The type of services already provided by the area's other health resources will be a major determinant of the services to be included in a community mental health center's program.

The Planning Project concerned itself primarily with the general nature of comprehensive programs. Local people should determine the character of a specific program's services. Further, the precise manner in which publicly and privately supported agencies coordinate their services can only be determined at the local level. This decision might very well come within the purview of the area's mental health board. Only through local deliberation can idiosyncratic factors be considered in establishing programs which are sufficiently flexible to provide services to the community as clinically indicated, and not as they are administratively regulated.

Utmost stress must be placed upon the imperative necessity of hiring a local program's director, and even his assistant, during the earliest phase of planning. Rather than imposing a total program upon a community, the director can gradually develop the necessary liaisons to clarify within the community the scope of services to be provided through the mental health center.

The Deployment of Resources

In most areas of the state a comprehensive mental health program will not be administratively centered or controlled in any single facility but will require the coordination of several resources. To be truly effective, major and minor realignments must be undertaken in agency relationships.

Mental Health and Non-Mental Health Resources

Relations between these two groups of resources have generally developed more by chance than through any mutual recognition of the benefits that planned interaction could produce. As mental health programs assume responsibility for the provision of services to all members of the community, the collaboration of a wider range of non-mental health resources must be obtained.

Mental disorders of lower socioeconomic groups are so intertwined with real social problems that they rarely can be solved through the skills of the psychiatrist alone. In the foreseeable future, it is possible that the mental health problems of these groups will be the responsibility of agencies such as the welfare department, settlement house, and public health nursing association. In these instances, the primary job of the mental health professional would be to provide other community resources with consultation, training and additional types of direct and indirect support. The mental health program itself will be focusing less of its resources upon patient care and more upon the indirect techniques of consultation and community organization with non-mental health resources.

As mental health programs develop an interest in the area of primary prevention and initiate activities which traditionally have been within the domain of social and welfare agencies, there will be inevitable conflicts which could be potentially detrimental to effective program coordination. A realignment of agency relationships can minimize this conflict, if meaningful communication and increased mutual trust are exercised by all participants.

Mental health facilities should routinely participate in local community welfare councils as one way of promoting mutual trust and establishing communication. This step will also enhance the integration of mental health services with related programs such as housing, poverty and delinquency control. It is vital and necessary that staff members at the mental health center initiate the reaching out to other significant community resources rather than waiting to be involved.

Publicly, Voluntarily and Privately Supported Mental Health Programs

Components of these systems have coordinated their efforts harmoniously but by and large relationships have not been cultivated as carefully as is necessary. The federal appropriation of construction funds for new mental health centers again focused attention upon the cleavages between these systems and pointed up the need for resolution of outstanding differences.

In seeking a solution to these problems, an explicit principle states that active participation of publicly, voluntarily and privately supported resources is imperative for the provision of comprehensive services to any community. No system can cope with the vast extent of current needs by itself. This situation will continue for many years to come.

A history of legal and attitudinal obstacles limited the role of voluntarily and privately supported resources and prevented their being used in an optimal fashion. Segments of the non-publicly supported systems whose roles require the most clarification are the general hospital, the private practitioner and the social service agency.

With the program goal of local inpatient services in all major communities throughout the state, the facilities of the general hospital will be critical, especially in non-metropolitan areas. Inpatient services of a community mental health program should be located so they are accessible to the medical services of a general hospital. The administration and staffing of such a program should be by either state or general hospital supported personnel, depending upon the arrangement which is most suitable to the particular community.

Because of the legal restrictions of the Massachusetts constitution's anti-aid amendment, the state cannot allocate grants-in-aid to a psychiatric program administered by the general hospital. However, the state can arrange to reimburse the general hospital legally and equitably for care provided local citizens on a fee-for-service contract basis or on a loaned personnel basis. Reimbursement to the hospital should be based upon a formula which includes standard accounting costs as well as additional items such as administrative, standby and community service costs.

Private practitioners should be permitted to hospitalize and treat their patients in the facilities operated by state-supported programs, when clinically indicated. Arrangements might be administered most effectively by giving the private practitioner either a staff or consultant appointment. This procedure had been opposed in the past on the grounds that granting private practitioners staff privileges would produce major disrupting results. However, the Planning Project's survey of psychiatrists in private practice revealed that only a minority routinely participated in the hospital treatment of their patients and therefore their effect upon hospital routines would be minimal.

State reimbursement for professional services provided inpatients in a general hospital should be made on a straight per diem basis rather than by actual type of service provided. In this way financial considerations will not become a parameter affecting the patient's treatment program and he will receive those services indicated by his daily clinical condition.

The previously discussed use of general hospitals and private practitioners is recommended for providing specific elements of a comprehensive program. They will not replace the other resources which will still be necessary to provide the remaining service elements. General hospitals and private practitioners must cooperate with the total system to make inpatient services an effective part of the whole.

Other resources in the voluntary and private systems of social service agencies will be confronted by a variety of possibilities if they choose to become integral members of their community's comprehensive mental health program. The fact that many of these agencies already provide major mental health services was clearly demonstrated by the results of the 1962 Boston Mental Health Survey. Any of the following options might be considered by a particular facility in determining its future role:

- Continue current intake and treatment practices with patients making financial arrangements directly with the agency.
- Continue to function independently but develop a contract with the area mental health board to provide treatment to selected patients on a fee-for-service basis.
- Continue to function as an independent facility but arrange a contract with the area mental health board whereby publicly supported personnel are assigned to the facility to treat patients unable to pay for private services.
- Alter the facility's administrative structure so that it is financed and operated as a publicly supported mental health resource bringing it under the control of the area mental health board.

Other options are possible and the choice of a particular one will depend upon local circumstances.

Department of Mental Health Resources

No state supported facility currently provides a complete comprehensive program by itself, although some come much closer than others. The provision of comprehensive, well-coordinated services in all areas of the state requires a major reconceptualization of the functional purposes of existing publicly-supported state hospitals and mental hygiene clinics. Although both systems are rooted in different historical developments and areas of interest, there is no insurmountable barrier to their providing the necessary broad range of services.

The use of the Department of Mental Health facilities will vary in urban and rural areas, teaching and non-teaching programs, and chronic care and acute treatment facilities. An appropriate model should be selected in a way which incorporates vital conceptual principles.

The State Hospital Massachusetts currently has a major investment in the mental hospital system, both in terms of financial capital and personnel resources. It is incumbent upon planners to make wise use of these facilities. Within a statewide scheme for comprehensive services, mental hospitals are viewed as serving two distinct purposes. The first is the provision of the five essential services in a comprehensive mental health program to the geographic area in which it is located. The second purpose is to provide continued treatment facilities for its own local area as well as for neighboring community mental health programs.

It will be important to facilitate the free movement of patients between outpatient clinics, acute inpatient services and continued care facilities. In those instances where a state hospital provides continued care for several community programs, the hospital

might well consider establishing a geographic unit system on the continued treatment service as one way of facilitating two-way communication and transfer of patients with local centers. When geographical distance is not an issue, the state hospital and its neighboring community mental health centers could experiment with an arrangement whereby each center is responsible, or participates, in the professional staffing of its unit.

Mental Hygiene Clinics The magnitude and scope of services provided by the existing mental hygiene clinics vary greatly. Wide differences are also found in geographical distance to the nearest hospital and in the type of relations developed with the hospital. Because of these differences, the manner in which the clinics are integrated into a system of regionalized programs will be based upon individual considerations. At least three general patterns are foreseen:

- A mental hygiene clinic, often in conjunction with a general hospital, will undertake the responsibility for providing a full range of services to its entire area by expanding its current program, e.g. South Shore Mental Health Center.
- A mental hygiene clinic and a mental hospital already do, or should, serve the same geographical area. Their programs will be coordinated under a single administrator, although children's services will remain a distinct functional entity, e.g. Worcester Youth Guidance Center and Worcester State Hospital.
- A mental hygiene clinic has provided a range of services to only a limited part of a service area and it does not appear indicated that it should expand beyond this range of services, or limited area. Such a clinic will develop a semi-autonomous single administrator affiliation with the mental health center serving the entire region, e.g. the Brookline Mental Health Clinic and the Massachusetts Mental Health Center.

Teaching Hospital-Medical School Centers Separate and apart from the expansion and/or coordination of existing services will be the development of fresh programs under new administrative arrangements with medical schools such as the Government Center, Boston University and Tufts University Mental Health Centers and the new University of Massachusetts Medical School.

Realignment of the Department of Mental Health facilities will require major and minor changes in the Department's table of organization. When rendering comprehensive services to a local area, it makes little sense to have each unit in the program remain directly responsible to the central office of the Department. A local administrator who provides direction and liaison between the central office and all of the Department's local units could make the over-all program function far more effectively than if it remains disjointed. A proposed new table of organization for the Department of Mental Health which provides the administrative structure for developing community mental health programs is presented in the section on administration.

A further consideration in this regard is the need to establish true citizen participation in the efforts of the local center through a formal administrative structure. Planning Project recommendations strongly affirm the principle of citizen participation.

Implementation

Statewide community mental health programs will not be achieved within one or two years, but are rather a goal to be pursued during the coming decade. A phasing process will be necessary. The speed with which they evolve will depend upon such factors as community participation and interest and the availability of voluntary, local, state, and federal financial support.

All segments of the Department of Mental Health's far-flung system will be affected. No existing facility will remain untouched during the coming decade. As new mental health centers are built and accept inpatients from their local areas, the state hospitals will be relieved of a major portion of their current service loads. Then, they will be able to divert their resources to other endeavors and ultimately be in a position to function as true community mental health centers.

REGIONALIZATION

Key Recommendations

18. Comprehensive mental health services should be provided in each of the 37 planned mental health areas in the state.

19. Continued inpatient care for individuals requiring extended hospital care should be provided through 12 mental hospitals.

Each mental hospital will be responsible for the continued care program of several local areas.

20. Six major regions should be established to permit the decentralized administration of local programs.

This will also permit the coordination of local mental health programs with court clinic programs and services to the mentally retarded.

A cornerstone in the development of statewide community mental health programs is the delineation of specific local areas where services will be provided. Without a definite geographic service base, it is virtually impossible for a mental health program to develop the community liaisons necessary for the provision of comprehensive care.

Federal regulations clarifying the 1963 Community Mental Health Centers Act indicate that each mental health facility shall serve a population of not less than 75,000 and not more than 200,000 persons. Exceptions to this requirement can be permitted by the Surgeon General if he finds that modifications will not impair the effectiveness of the services to be provided. The location of metropolitan areas and the rapid expansion of suburbs in Massachusetts necessitated the delineation of some areas which are smaller and some that are larger than the prescribed population limits. In no case will this impair the provision of services. On the contrary, it will permit the strengthening of programs while still preserving natural community boundaries.

Rationale for Regionalization

A rationale based upon nine points was followed in developing service areas:

- Specific boundary lines were not intended to prevent a facility from accepting patients outside its area if it wished to do so and if the patient also desired. Such decisions will remain the prerogative of the individual facility. Specific boundary lines were set to insure that each mental health program accepted the responsibility for providing necessary service to all citizens residing within its area and for the development of rational service areas for mental health coordination, consultation and education.
- Federal regulations regarding population were adhered to whenever possible.
- No single existing model of comprehensive services could be imposed upon every area of the state. Because of the variety of program models which developed in the Commonwealth, the planning of comprehensive programs in individual regions had to consider local tradition and relations. Therefore, it should be explicitly understood that the Planning Project recommended service areas. The precise manner in which existing and planned resources within a given area coordinated their efforts to provide a comprehensive program had to be left to local discretion and decided by community representatives in cooperation with other appropriate bodies.
- The state had a tremendous investment in the mental hospital system, both in terms of financial capital and personnel resource. Because of the importance of these institutions in continuing care of patients, it was incumbent that planning make wise use of these facilities. Within a statewide scheme for regionalization, mental hospitals were viewed as serving two distinct purposes; providing the five essential services in a comprehensive mental health program to the immediate geographic area in which it is located and providing continued treatment facilities for its own area as well as for several contiguous community mental health programs.
- Existing mental hygiene clinics varied considerably in the magnitude and scope of their services, geographical distance to the nearest state hospital and the nature of their relations to that hospital. Therefore, the integration of these clinics into a system of regional programs had to be based upon individual considerations.
- Since marked disparity existed between the areas served by mental hygiene clinics and the state hospitals, the district lines already established for the clinics were followed wherever possible in outlining new areas. This principle was based upon the idea that the clinic district lines are smaller and generally stem from more recent efforts to integrate neighboring communities into a cohesive partnership for the provision of services. In contrast, state hospital districts reflected a variety of administrative needs during the past decades and often had little basis in terms of present community needs and relationships.
- In addition to the expansion and/or coordination of existing services, new programs had to be developed under separate administrative arrangements such as the Government Center, Boston University, and Tufts University Mental Health Centers.

- New areas developed for mental health programs had to facilitate the provision of services to district courts and to centers serving the mentally retarded.
- Wherever possible, the logical areas for regional planning developed in December, 1960 by the Massachusetts Department of Commerce were followed. These areas were based upon the inclusion of criteria such as service areas of general hospitals, standard metropolitan statistical areas, existing and proposed limited access highways and physical contiguity to urban centers.

Geographic Services

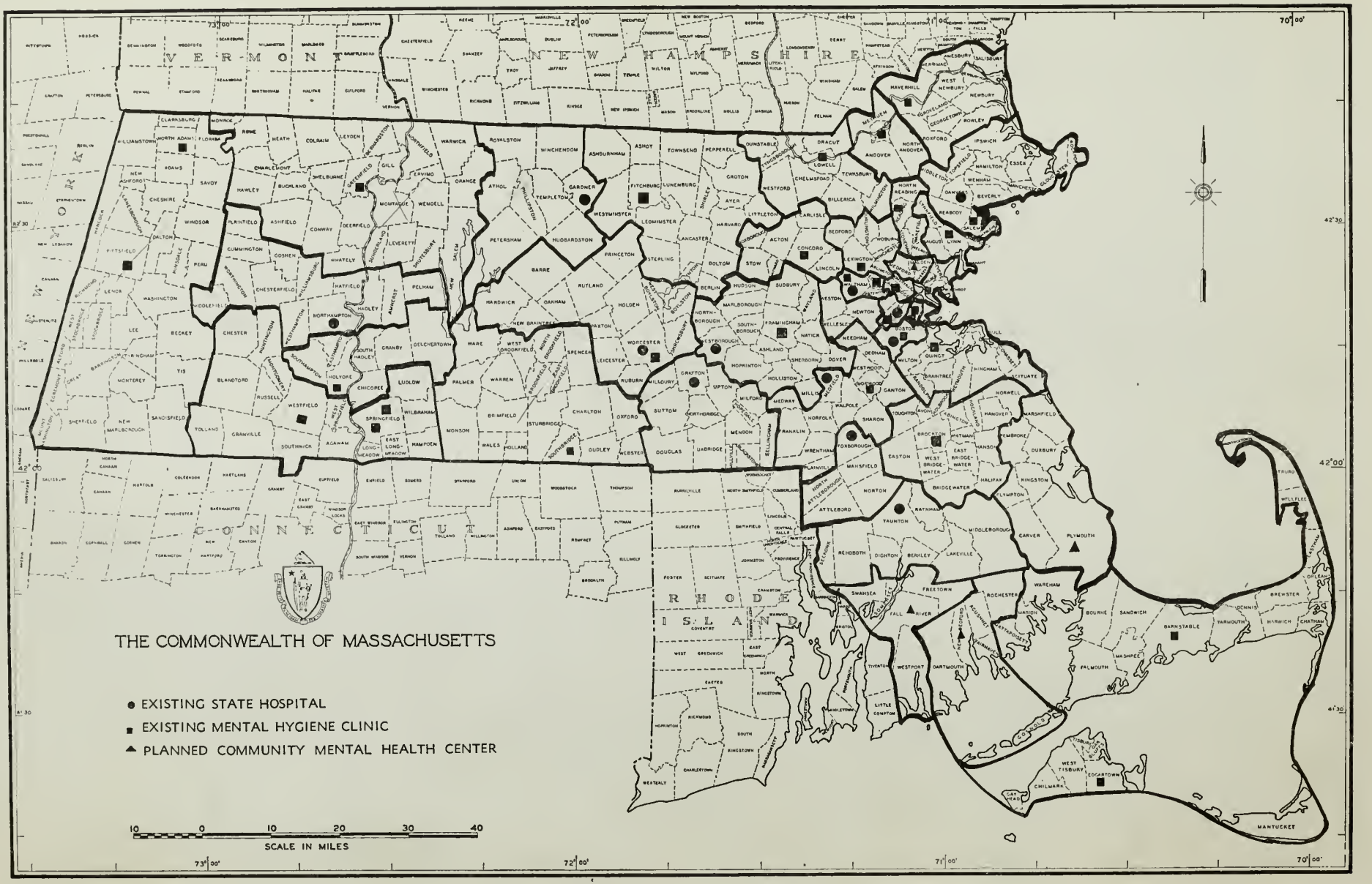
The Project developed a statewide plan to provide necessary services at three geographic levels.

Thirty-seven community mental health areas will be established to provide the essential elements of a comprehensive program: acute inpatient care, outpatient treatment, emergency services, partial hospitalization, and consultation and educational services. (See map.)

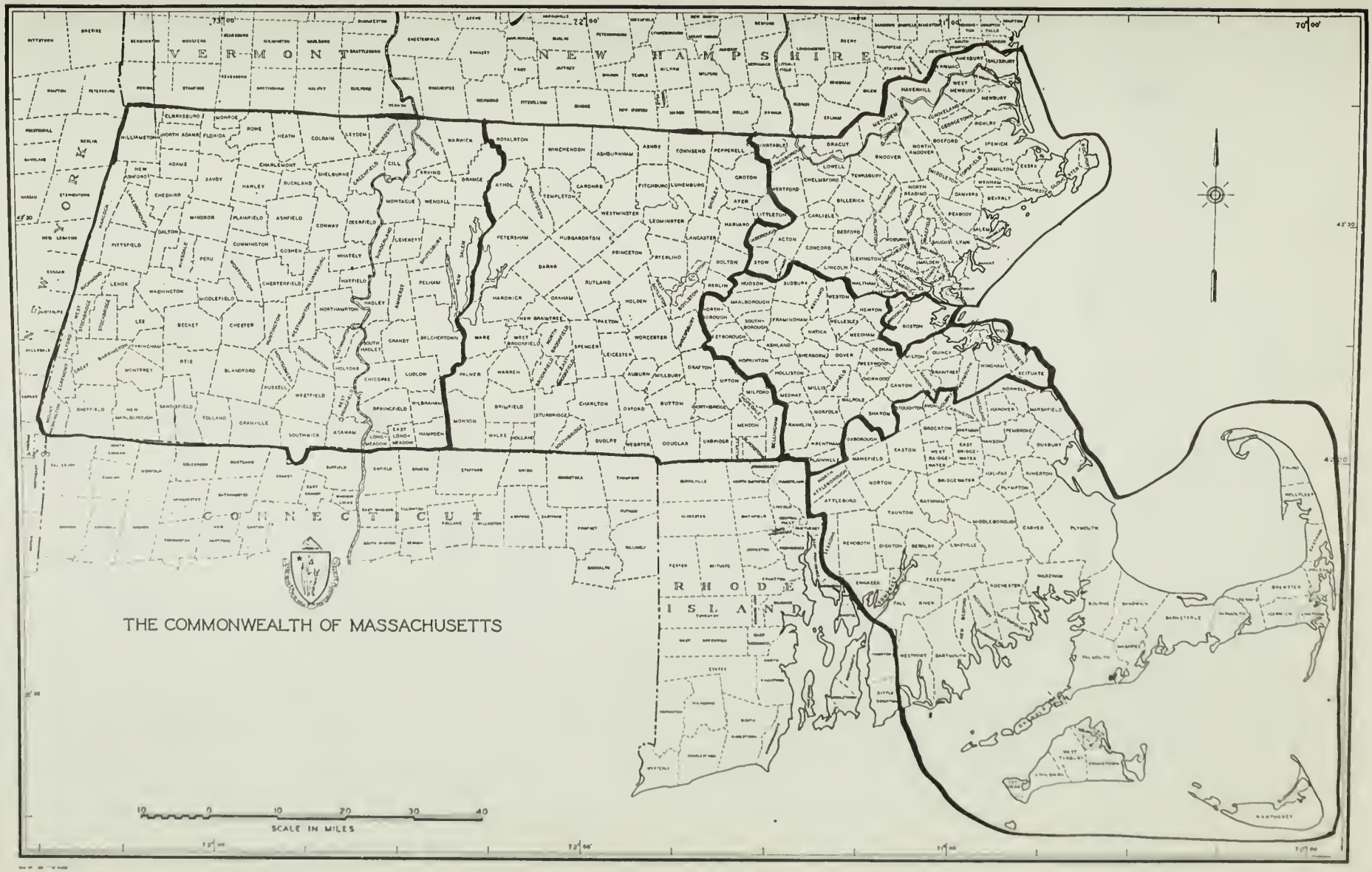
Twelve large mental hospital areas will be used to provide continued treatment for patients requiring prolonged inpatient care. Every existing mental hospital will provide this service for residents of its own local area as well as for residents of neighboring community mental health areas. It is anticipated that patients discharged from the mental hospital to the community will be referred back to their local center for necessary aftercare services.

Six major regions will be used to decentralize administrative responsibility in the Department of Mental Health and for the coordination of related programs such as those provided through the district court clinics and facilities for the mentally retarded. (See map.)

THE 37 PROPOSED COMMUNITY MENTAL HEALTH AREAS



THE SIX PROPOSED COMMUNITY MENTAL HEALTH REGIONS



Consensus on Areas

Preliminary drafts of the Project's regionalization recommendations were given wide distribution allowing local citizens to make appropriate suggestions. Drafts were distributed in the fall and winter of 1964 to local mental health associations, community councils, hospital superintendents, clinic directors and many other individuals who had expressed interest in this problem. Consensus was achieved by the spring of 1965 that the proposed groupings represented appropriate areas within which to plan for comprehensive mental health services.

Areas listed will be subject to annual review and should not be regarded as fixed and unchangeable. Since the intent behind the development of specific areas is to provide services as effectively as possible, modifications can be made on the basis of information emerging from public hearings, community surveys, comments of local representatives and similar sources.

List of 37 Areas

Table 1 lists the 37 planned mental health areas and the mental hospitals with which they will be affiliated for continuing care of patients requiring prolonged inpatient treatment. Information is also given about the size of each area and its density (number of people per square mile).

TABLE 1

Planned Community Mental Health Programs for Massachusetts by Community Mental Health Center, Region Served, Population, Density, Square Miles Served and Continuing Care Hospital.

Community Mental Health Center and Region Served	*Population*	*Square Miles Served*	*Density**	*Continued Care Hospital*	*Total Pop.*
Boston State Hospital Hyde Park, Roslindale, West Roxbury, Dorchester South, Dorchester Central (tracts T4A, T4B, T5A, T5B, T7B, T8A, T8B, T9, T10, X1)	230,187	N.A.†	N.A.		
Boston University Mental Health Center South End (less tracts G1, G2, G3, G4), Back Bay (tracts J3, J4, K3, K5), Roxbury (less tracts S2, S4, S5, S6, V2), Dorchester North (less tract T1)	158,065	N.A.	N.A.	Boston State Hospital	651,801
Massachusetts Mental Health Center Brighton, Brookline, Jamaica Plain, Back Bay (tracts K4A, K4B, J5, S1), Roxbury (tracts S2, S4, S5, S6, V2)	205,992	N.A.	N.A.		
Tufts Mental Health Center South End (tracts G1, G2, G3, G4), South Boston, Dorchester North (tract T1)	57,557	N.A.	N.A.		
Danvers-Salem Mental Health Center Beverly, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester, Marblehead, Middleton, Peabody, Rockport, Salem, Topsfield, Wenham	208,442	195.43	1,069		
Government Mental Health Center Charlestown, Chelsea, East Boston, North End, Revere, West End, Winthrop	185,180	N.A.	N.A.		
Haverhill Mental Health Center Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury, West Newbury	93,760	181.14	518	Danvers State Hospital	727,503
Lynn Mental Health Center Lynn, Lynnfield, Nahant, Saugus, Swampscott	140,796	35.38	3,979		
Reading Mental Health Center Melrose, North Reading, Reading, Stoneham, Wakefield	99,325	41.24	2,408		
Foxborough State Hospital Attleboro, Foxborough, Mansfield, North Attleboro, Norton	66,622	114.47	582		
Brockton Mental Health Center Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Halifax, Hanover, Hanson, Holbrook, Norwell, Rockland, Stoughton, West Bridgewater, Whitman	185,410	232.82	796	Foxborough State Hospital	252,032

* Number of people per square mile.
† Not available.

TABLE 1—(Continued)

Community Mental Health Center and Region Served	*Population*	*Square Miles Served*	*Density**	*Continued Care Hospital*	*Total Pop*
Fitchburg Mental Health Center Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Groton, Harvard, Lancaster, Leominster, Littleton, Lunenburg, Pepperell, Shirley, Sterling, Townsend, Westminster	148,643	433.26	291	Gardner State Hospital	194,528
Gardner Mental Health Center Athol, Gardner, Hubbardston, Petersham, Phillipston, Royalston, Templeton, Winchendon	45,885	288.68	158		
Grafton Mental Health Center Bellingham, Blackstone, Douglas, Grafton, Hopedale, Mendon, Milford, Millbury, Millville, Northbridge, Sutton, Uxbridge, Upton	83,438	248.43	336	Grafton State Hospital	83,438
South Shore Mental Health Center Braintree, Cohasset, Hingham, Hull, Milton, Quincy, Randolph, Scituate, Weymouth	251,417	121.84	2,060		
Medfield-Norwood Mental Health Center Canton, Dedham, Franklin, Medfield, Medway, Needham, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham	157,508	208.69	755	Medfield State Hospital	535,641
Newton Mental Health Center Newton, Wellesley, Weston	126,716	44.75	2,832		
Metropolitan-Beaverbrook Mental Health Center Belmont, Waltham, Watertown	123,220	21.07	5,848		
Concord Mental Health Center Acton, Boxboro, Carlisle, Concord, Lincoln, Maynard, Stow	37,868	108.26	351		
Malden Mental Health Center Everett, Malden, Medford	166,191	16.66	9,975	Metropolitan State Hospital	681,747
Mystic Valley Mental Health Center Arlington, Bedford, Burlington, Lexington, Winchester, Woburn	152,055	66.00	2,304		
Cambridge Mental Health Center Cambridge, Somerville	202,413	10.18	19,883		
Franklin County Mental Health Center Ashfield, Bernardston, Buckland, Charlmont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Rowe, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, Whately	54,864	700.90	78		
Northampton Mental Health Center Amherst, Chesterfield, Cummington, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, Worthington	55,439	327.95	169	Northampton State Hospital	
Springfield Mental Health Center Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Longmeadow, Ludlow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, Wilbraham	296,799	464.43	639		

* Number of people per square mile.

TABLE 1—(Continued)

Community Mental Health Center and Region Served	*Population*	*Square Miles Served*	*Density**	*Continued Care Hospital*	*Total Pop.*
Berkshire County Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mt. Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor	142,135	926.38	153	Northampton State Hospital	702,360
Holyoke-Chicopee Mental Health Center Belchertown, Chicopee, Easthampton, Granby, Holyoke, South Hadley, Southampton	153,123	184.23	825		
Taunton Mental Health Center Berkley, Dighton, Lakeville, Middleboro, Raynham, Rehoboth, Seekonk, Taunton	78,286	270.36	290		
Plymouth Mental Health Center Carver, Duxbury, Kingston, Marshfield, Pembroke, Plymouth, Plympton	37,911	243.65	156		
Fall River Mental Health Center Fall River, Freetown, Somerset, Swansea, Westport	131,734	149.71	880	Taunton State Hospital	481,801
New Bedford Mental Health Center Acushnet, Dartmouth, Fairhaven, New Bedford, Rochester, Gosnold	138,803	143.81	965		
Barnstable County Mental Health Center Barnstable, Bourne, Brewster, Chatham, Dennis, Eastham, Falmouth, Harwich, Marion, Martha's Vineyard, Mashpee, Mattapoisett, Nantucket, Orleans, Provincetown, Sandwich, Truro, Wellfleet, Wareham, Yarmouth	95,067	511.98	174		
Lowell Mental Health Center Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsborough, Westford, Wilmington	177,542	184.15	964	Tewksbury State Hospital	303,375
Lawrence Mental Health Center Andover, Lawrence, Methuen, North Andover ..	125,833	86.89	1,448		
Westborough-Framingham Mental Health Center Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Millis, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough	167,974	266.32	631	Westborough State Hospital	167,974
Southbridge Mental Health Center Brimfield, Brookfield, Charlton, Dudley, East Brookfield, Holland, Monson, North Brookfield, Oxford, Palmer, Southbridge, Spencer, Sturbridge, Wales, Ware, Warren, Webster, West Brookfield	100,679	463.92	217	Worcester State Hospital	357,986
Worcester Mental Health Center Auburn, Barre, Boylston, Hardwick, Holden, Leicester, New Braintree, Oakham, Paxton, Princeton, Rutland, Shrewsbury, West Boylston, Worcester	257,307	370.50	694		

* Number of people per square mile.

Six Administrative Regions

It had been indicated earlier that the state should be divided into six major regions for purposes of decentralizing the administration of local programs as well as to permit coordination of court clinics and facilities for the mentally retarded. Therefore, it is recommended that the 37 planned community mental health program areas and the twelve continued care areas be organized into six major administrative regions as follows:

Region	*Community Mental Health Program Area*	*Continued Care Area*	*Population*
I.	Berkshire, Franklin, Holyoke, Northampton, Springfield	Northampton	702,360
II.	Fitchburg, Gardner, Grafton, Southbridge, Worcester	Gardner, Worcester, Grafton	635,952
III.	Cambridge, Concord, Danvers, Government Center, Haverhill, Lawrence, Lowell, Lynn, Malden, Metropolitan, Mystic Valley, Reading	Danvers, Metropolitan, Tewksbury	1,712,625
IV.	Medfield, Newton, South Shore, Westborough	Westborough, Medfield	703,615
V.	Boston State, Boston University, Massachusetts Mental Health Center, Tufts University	Boston State	651,801
VI.	Barnstable, Brockton, Fall River, Foxborough, New Bedford, Plymouth, Taunton	Foxborough, Taunton	733,833

Appropriate administrative structures for insuring effective operation of programs at each geographic level are described in the chapter on Administration.

ADMINISTRATION AND CITIZEN PARTICIPATION

Key Recommendations—Administration

21. The Central Office of the Department of Mental Health should be reorganized. Five Divisions, each headed by an Assistant Commissioner, will emphasize decentralization of administration. The Five Divisions will cover activities in retardation, professional services, community programs, administration and special programs.

22. Regional administrative structures should be established under the supervision of Regional Mental Health Directors. They should develop, administer, integrate, coordinate and evaluate the comprehensive mental health programs of the region.

23. Separate region-wide budget requests should be submitted by each region as part of the total Department request. Authority should be given to the regional administration to make "in line" budget transfers in the operating budget without legislative or administrative approval.

24. Local administrative structures should include an Executive Director and a Medical Director. Either of these persons could be designated the Senior Program Administrator.

25. Responsibility for making program policy should be shared by the regional and local mental health areas. Whenever possible, maximum responsibility should be within the local community mental health area.

Key Recommendations—Citizen Participation

The following recommendations pertaining to citizen participation apply to state-supported services and facilities as a part of the comprehensive community mental health centers.

26. Each of the 37 area centers should have a Community Mental Health Board.

27. Each of the six regions should have a Regional Mental Health Committee.

28. A statewide Mental Health Council should be associated with the Department of Mental Health.

29. These citizen advisory groups should be organized as semi-public bodies with a wide community representation.

30. These citizen bodies should eventually replace the state hospital trustee system and the clinic board system.

31. The regional mental committees should have the power to approve the regional budget and to ratify changes made in it.

32. A pilot or demonstration regional committee should be established as soon as possible along with a regional administrative unit.

33. The citizen bodies should have professional and administrative staff assistance to further their assigned responsibilities and duties.

34. The citizen bodies, in cooperation with the Department of Mental Health, should participate in the sponsorship of regularly scheduled public hearings throughout the state.

THE ADMINISTRATION OF MENTAL HEALTH SERVICES IN MASSACHUSETTS

A Frame of Reference

Before discussing the current and proposed Department of Mental Health administrative structure, a frame of reference is important. Thirty-seven community mental health programs have been projected. Many of the services to be included are currently, though not uniformly, part of the Department's program. They are offered under a legal umbrella in which the Commissioner of Mental Health bears ultimate executive responsibility for the care of the mentally ill in the Commonwealth and in which the legislature has ultimate responsibility for determinations regarding expenditure of state monies. Superimposed on this chain of responsibility is the anti-aid amendment to the state constitution which sets strict limitations on the state's right to make grants-in-aid to voluntary groups.[1]

As current services are supplemented with new ones, under the community mental health programs, it seems clear that the Commonwealth will remain the major provider of funds for construction and operation.

Difficulties inherent in changing our constitution (particularly when such complex issues as church-state relationships are involved) preclude the likelihood of removal of the constitutional structures. It is also quite unlikely that the legislature will give up its financial control or relieve the Commissioner of Mental Health of his administrative responsibility. For these reasons this discussion of the administration of the Department's programs is set within a frame of reference in which the state supported elements of the community mental health programs are an integral part of the Department of Mental Health operation. Of course, valuable and varied services will continue to be offered outside Departmental auspices.

As the nature of the Planning Project's proposed community programs began to crystalize and as regional and local service areas began to take form, it became clear that the current arrangements for the administration of mental health services required both structural and functional alteration. An appraisal of the current structural-functional arrangements and the pinpointing of changes needed to accommodate to community mental health programming was required. Such an appraisal called for an examination of both the actual structure and table of organization of the Department's staff and the relations maintained with voluntary citizens' groups which work with the Department. These were not two discrete areas of inquiry. For example, the degree to which administrative authority is vested in local community boards will alter administrative arrangements within the central office of the Department of Mental Health. For purposes of analysis, they will be examined separately.

Administrative Structures

The current Department of Mental Health service structure might be termed a "multipyramidal line model." Each service is provided through a functional division quartered in the central office.

The Division of Mental Hygiene is responsible for the community clinic programs and some preschool services to the retarded.

The Division of Legal Medicine operates the court clinic program and, in cooperation with the Department of Correction and the Division of Youth Service, treatment programs for sexually dangerous persons and other adult and juvenile offenders.

State hospitals, as a unit, are responsible to the First Assistant Commissioner.

State schools for the retarded were recently placed under the authority of the Third Assistant Commissioner for Retardation. Additionally there are central office staff positions in medical statistics, hospital inspection, public information and personnel. There are also chiefs of psychology, social work, occupational therapy and nursing. The Commissioner is aided by two special assistants, for medical and executive affairs. Business and administrative matters are the responsibility of the Second Assistant Commissioner.

While the divisions are accurately described as line units, the degree of actual control and direction varies. It is least evident in the institutions which tend to operate more or less autonomously from the central office.

The analysis of any organization's administrative structure has meaning only in relation to its function. Over the past few decades, the Department of Mental Health has assumed a national leadership role in bringing services to the community. However, in common with other states, Massachusetts has expended the largest portion of its resources for the more traditional institutionally-based services. Therefore the basic program imperative has been not the flexibility to meet the needs of disparate individual communities, but rather to provide a consistent level of service for a relatively small number of institutions, each of which serves a quite heterogeneous population. In such circumstances, the centralized line operation is appropriate, and the present Department of Mental Health structure has been adequate for its task.

As the prime focus of mental health care shifts to community programs, different functions emerge

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[1] Massachusetts Constitution, Articles of Amendment, No. 46, Section 2 . . . "and no grant, appropriation or use of public money or property or loan of public credit shall be made or authorized by the Commonwealth or any political division thereof for the purpose of founding, maintaining or aiding any school or institution of learning, whether under public control or otherwise, wherein any denominational doctrine is inculcated, or any other school, or any college, infirmary, hospital, institution, or educational, charitable or religious undertaking which is not publicly owned and under the exclusive control, order and superintendence of public officers or public agents authorized by the Commonwealth or federal authority or both, except that appropriations may be made for the maintenance and support of the Soldiers' Home in Massachusetts and for free public libraries in any city or town, and to carry out legal obligations, if any, already entered into; and no such grant, appropriation or use of public money or property or loan of public credit shall be made or authorized for the purpose of founding, maintaining or aiding any church, religious denomination or society."

"SECTION 3. Nothing herein contained shall be construed to prevent the Commonwealth, or any political division thereof, from paying to privately controlled hospitals, infirmaries, or institutions for the deaf, dumb, or blind not more than the ordinary and reasonable compensation for care or support actually rendered or furnished by such hospitals, infirmaries or institutions to such persons as may be in whole or in part unable to support or care for themselves."

and existing structures must be altered to accommodate them. The new emphasis must be on coordination of specific local programs and this calls for greater decentralization of the decision-making power to the regional and local levels of operation. It is not enough to change job titles or reassign duties. What is needed to meet these new functional demands is a new administrative model for the Department. The following discussion details responsibilities and functions involved in the proposed table of organization. (See Table of Organization chart on page 46.)

Central Office

Office of the Commissioner

Under the law, the Commissioner of Mental Health bears ultimate responsibility for the administration of the Department. This should not be changed and is appropriate. In a latter section of this report, the role of the Advisory Council to the Department of Mental Health is discussed.

Deputy Commissioner

One of the responsibilities of the current First Assistant Commissioner has been to oversee the Department's institutional programs. This responsibility has been a demanding one and has limited the time available for him to act in the capacity of second in command of the total program.

In terms of funds expended and people served the Department of Mental Health is a major administrative enterprise. As such, it must be able to deal authoritatively with a wide range of interests, both public and private, and concurrently deal with the Department's continuing internal administrative needs.

It is recommended that under the Commissioner's supervision, the Deputy Commissioner share and be delegated some of the general administrative authority of the Department of Mental Health, as the Commissioner deems appropriate.

To reflect the new functions of the role, the position of First Assistant Commissioner should be replaced by the position of Deputy Commissioner.

Assistant to the Commissioner (Legal Counsel)

Increasingly, program operations require legal and quasi-legal decisions by the Department. Unlike most departments in the Commonwealth, there is no legal counsel in the Department. Contract review, court representation and other legal services are provided by the office of the Attorney General. Additionally, the Department is fortunate in having on its staff a legally trained Third Assistant Commissioner. An Assistant to the Commissioner, though not trained as a lawyer, has mastered many of the relevant legal skills and insights. However, and particularly when the present incumbents complete their service to the Commonwealth, the services of a legal counsel should be institutionalized into the Departmental table of organization.

Duties currently assigned to the Assistant to the Commissioner (Executive) should be carried out by this person. He should be responsible for legislative liaison, labor relations and hearing administrative appeals within the Department. In addition, he should advise the Commissioner regarding the legal implications of Departmental operations, review all contracts and maintain liaison with the office of the Attorney General. A similar recommendation has been made by the Special Legislative Commission on Mental Health.

Assistant to the Commissioner for Planning

Although this report marks the completion of federal participation in planning, it is clear that planning must be a continuing process in an enterprise the size of the Department of Mental Health. For example, the new community mental health programs will require evaluation and adjustment.

Duties of this unit should include the conceptualization of ideas, collection and organization of data, articulation of programs of long and short range and implementation of the Department's responsibilities through reports and proposals. Consistent with these responsibilities there should be sub-units within the Planning Division concerned with program development, community activities, operational research and statistics. The Assistant to the Commissioner for Planning should integrate the activities of these sub-units and coordinate their programs with those of other units within the central office and throughout the Department. He should also be responsible for developing improved liaison with other state-level government agencies, with the appropriate federal departments and with voluntary agencies involved in planning for mental health within the Commonwealth. Additionally, he should have responsibility for conducting an annual review of the State Mental Health and Mental Retardation Construction Plans as required by federal regulations.

Five Divisions

There should be five divisions within the central office of the Department of Mental Health covering activities in retardation, administrative services, professional services, community programs and special programs.

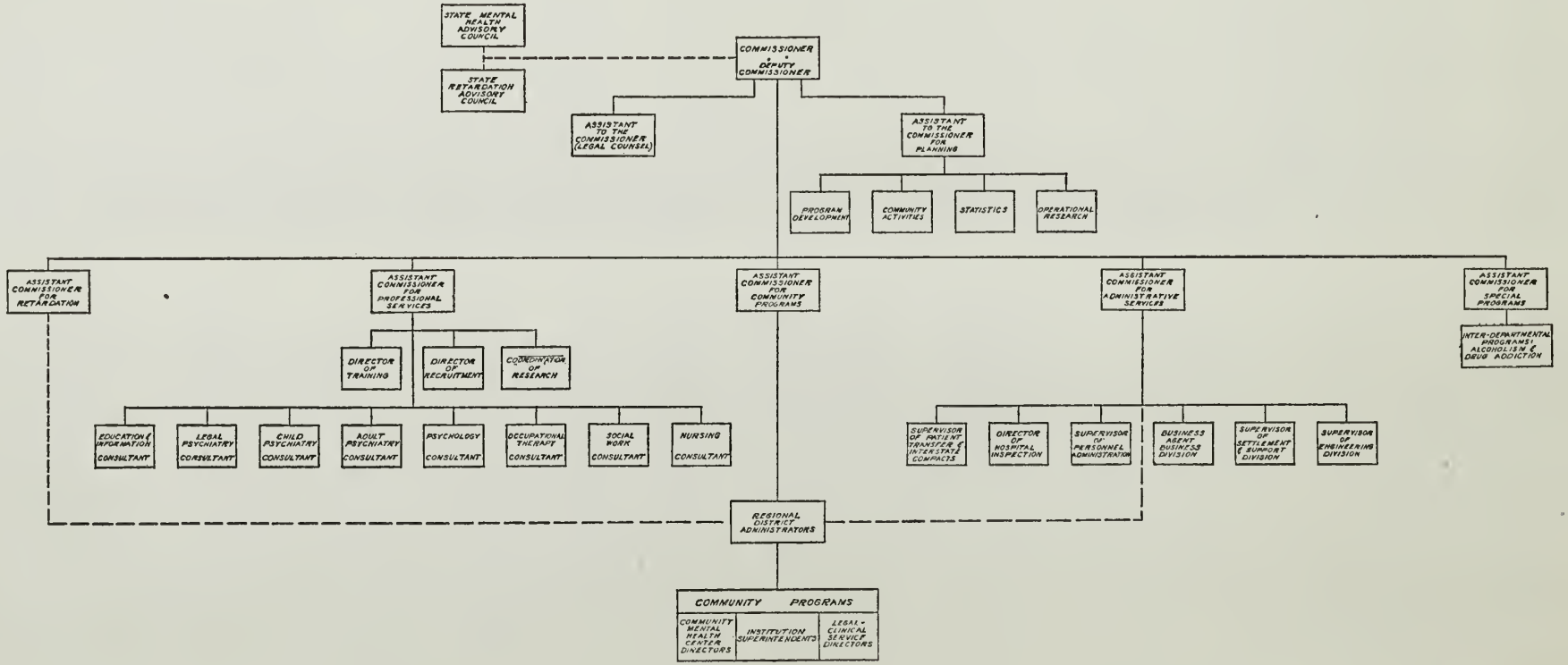
Division of Retardation Under an Assistant Commissioner for Retardation this division should be responsible for the coordination of Departmental and interdepartmental programs in retardation and the integration of such activity into the over-all community programs. In common with other planning for mental retardation, more detailed consideration of the structure and function of this division has been referred to the Mental Retardation Planning Project.

Division of Administrative Services An Assistant Commissioner for Administrative Services should assume the duties currently fulfilled by the Second Assistant Commissioner, Non-Medical Administration. In addition, the division's functions should include supervision of patient transfer and interstate compacts, hospital inspection and personnel supervision. Through his staff the Assistant Commissioner for Administrative Services should provide administrative services for the Department, maintain liaison with the regional offices and community programs and cooperate with their administrative personnel. When appropriate under state and Department regulations, the division should provide central administrative services for the regional and community programs.

Division of Professional Services Training, recruitment and research activities of the Department should

TABLE OF ORGANIZATION CHART

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
PROPOSED ORGANIZATIONAL CHART



be centered in the Division of Professional Services under the direction of an Assistant Commissioner for Professional Services. The directors of the training, recruitment and research sub-units should work closely together and with the Assistant Commissioner's staff consultants (or chiefs of service) in the various disciplines and special areas of practice such as psychology, social work and child psychiatry. Functions of the division should include the coordination of training, recruitment, research activities within the Department with special emphasis on the needs and interests of the disciplines and specific areas of practice, the establishment of Departmental standards and practices in training, the conduct of Departmentwide activity in these aspects of the total program and the coordination of pertinent regional and community efforts through consultation on these and other aspects of mental health practice and programming.

Division of Community Programs This Division should administer existing state hospital and mental health clinic programs through a system of regional and community units. An Assistant Commissioner for Community Programs should supervise and coordinate the community mental health services of the Department of Mental Health. His duties should include maintenance and review of program, personnel standards and budget review. Additionally, the Division should be responsible for the implementation of the comprehensive community mental health plan through the development and encouragement of new community programs.

The establishment of local area programs should be a shared responsibility. Consistent with the community mental health concept, program operation and program policy should be a local responsibility within the standards developed by the Department through the Division of Community Programs and other units. Primary supervisory authority should be at the regional level. However, the Assistant Commissioner for Community Programs should hear and adjudicate policy or priority disputes which cannot be resolved at the regional level.

In carrying out his duties, the Assistant Commissioner for Community Programs should work closely with the administrators and directors of the component regional and community units and should meet regularly with a committee of the regional mental health directors. He and his staff should maintain active liaison with other divisions and units of the Department in order to insure coordination of the total program.

Division for Special Programs Under the direction of the Assistant Commissioner for Special Programs this Division should have varied functions. Though the bulk of the Department's programs will be offered through decentralized facilities, some programs will have to be centralized. A case in point is the present program of the Division of Legal Medicine. Clearly the court clinics can be administered on a decentralized basis, most likely at the regional level. Aftercare services for released offenders, both adult and juvenile, from outside the Metropolitan Boston area could be provided by expanding the intake policies of such clinics. However, services within adult and juvenile institutions and the program for sexually dangerous persons do not lend themselves to decentralization. Nor does it seem appropriate to segment aftercare programs for released offenders within the Metropolitan Boston area. Therefore, a special Legal Medicine sub-unit should be established within the Division of Special Programs. This unit should provide services in adult and juvenile institutions, operate the program for sexually dangerous persons and offer comprehensive aftercare services for released offenders from the Metropolitan Boston area.

No doubt, some special interim programs will be necessary as comprehensive community programs develop throughout the state. Experience with the community programs will probably suggest other areas in which special units will be appropriate.

Throughout the body of this report there have been recommendations regarding the establishment of citizens' advisory groups such as a Manpower and Training Council, a Mental Health Communications Council and an Occupational Mental Health Council. Often advisory groups are forced to proceed without sufficiently articulated goals or functions and usually lack adequate staff assistance. A major reason for this is that these groups are nobody's primary responsibility. Administration often perceives them as inconvenient additions to already overloaded and understaffed operations. As a result, they rarely make a meaningful contribution. Collaboration with these advisory groups should be a principal responsibility of the Division of Special Programs.

Paralleling the above units, the Planning Project report recommends ad hoc or permanent study groups, both intra and interdepartmental in their scope such as a study of Bridgewater State Hospital and a study committee on epilepsy. Responsibility for the Department's role in such groups should be assigned to the Division of Special Programs. In both the citizen group and study committee activity, the Division's staff should be augmented by appropriate specialists from other divisions and units.

Administration at the Regional Level

An Administrative Model

It is strongly recommended that the regional level of the Department of Mental Health's community mental health programs operate through a structure which allows sharing of responsibility and authority by regional and local units with the maximum amount of authority possible placed at the local level. Such an approach may best be described as an administrative model. Program policy and operations should be a local affair in the approach recommended, remaining within the program and personnel standards set by the Department. The regional office should coordinate rather than supervise local programming, should arbitrate disagreements between component units and should provide special staff services or directly administer special programs when appropriate. Regional offices should have special authority in the areas of personnel and budgeting.

Some local-regional administrative relations are illustrated below:

- There should be joint regional-local responsibility for hiring top-level community personnel, e.g., administrative and medical direc-

tors. Others should be hired at the local level. This is intended to give considerable autonomy to the local programs. However, there is one major reservation. There are many intangibles which cannot be written into job specifications. In order to maintain service standards, it seems appropriate that the initiative in hiring should come from the regional or state level. Final authority, however, should be vested in the local program administrator.

- Each community program or institution should prepare a budget to be submitted to the regional director. He should have authority to alter and amend such requests and to integrate them into a single regional budget request which should in turn be submitted to the Commissioner of Mental Health for inclusion in the Department budget request. Component units should be given the opportunity to appeal any alterations in their budget requests made by the regional director. Such appeal should be to the Commissioner of Mental Health prior to submission of the final departmental budget request to the Governor.

Other Models Considered for Regional Administration

There were other options considered as models for regional units; "coordinative" and "directive." In order to understand the choice of the administrative model described earlier, we will discuss these other options.

In the "coordinative " model, the regional role is primarily advice giving and offering consultation and suggestions when sought. This role includes little program related decision making authority or policy formulation responsibility. It is most appropriate for the management of diverse unrelated programs and places maximum emphasis on local autonomy.

The "directive" model places maximum responsibility and authority at the regional level. Local program directors work under the direct supervision of the regional director and his staff. Such a model is most appropriate for the management of a series of nearly identical programs and places minimal reliance on local autonomy.

Administrative needs of the proposed community mental health programs are not fully met by the "directive" model. There will be certain basic program requirements for all programs, but not 37 almost identical units throughout the state. They will differ in terms of the amount of public involvement, the nature of local sponsorship and even in their internal structure, at times being a single community mental health center, at times a federation of separate public and private service units. Even within the six geographically distinct regions, which will serve between 480,000 and 1,700,000 people, there are likely to be different needs and treatment foci within each component local program. To accommodate such diversity under the "directive" model would require a complex staffing pattern, or a completely unmanageable administrative span of control. Additionally, it is highly unlikely that competent top-level local administrators would be willing to proceed with such curtailed administrative authority.

The "coordinative" model also poses problems. This model lacks adequate strength to insure the required comprehensive services in each mental health area. Community programs cannot be left completely to their own resources and initiative to develop services, but rather each community program should be part of an integrated plan. Such integration and coordination of clinical services can best be achieved at the intermediate regional level rather than at the central office of the Department of Mental Health.

There are other activities which require strong regional direction. Each of the local programs should relate to a state hospital for continued care. For the most part these continued care units will be part of but not under, the community programs. The local director will exercise no authority over the hospital administrator. A community concept calls for freedom of transfer between the local program and the state hospital without the necessity for regulatory systems. There are bound to be disagreements regarding the appropriateness of individual transfers. Probably there will also be questions regarding intake and treatment policy in the various programs. Many program related questions must be answered by authority outside the local program itself. Of course, basic policy questions should be settled at the central office level of administration. However, disputes arising from day-to-day program operations can best be arbitrated at the intermediate regional level.

Regional budgeting processes will also require that authority be vested in the region. Finally, many services cannot be provided at the local level either because of the nature of the service or lack of professional personnel required, or because of the particular populations served. Examples of the former are mental health education and public information. Ideally, each of the 37 area programs should have a mental health educator and a public information specialist especially trained in mental health concepts. However, such professionals are in short supply and for the most part the local units could be adequately served by regionally based mental health education and information units.

The latter service problem is best illustrated through the court clinic programs. There is general agreement among experts that the caseloads and treatment modalities in such programs do not lend themselves to complete integration into local community programs. It is thought that the district court clinic program functions best as a distinct administrative unit. Since there is little compatibility between court district and community mental health area lines, this can best be achieved at the regional level. By keeping administration at the intermediate level, it is possible to integrate the court clinic programs with local community mental health activities.

Regional Budgeting

Several references have been made to regional budgeting. This concept proposes a unique, but not wholly unprecedented, approach to departmental budgets within the Commonwealth. Except in those few departments which have been granted fiscal autonomy, line budgets are submitted. Once given legislative approval, they cannot be altered without administrative

(or legislative) clearance. For example, a budget line might be authorized for a psychiatric social worker in state hospital A, where for a variety reasons the position has not or cannot be filled. Meanwhile state hospital B may desperately need such a worker, have one immediately available, but have no open budgeted position. Under current procedures the unused job position could be transferred to the latter institution only with administrative approval from outside the Department. Approval may be difficult to obtain and involve considerable time delay. In addition, judgments which go into the granting of authorization are often far removed from the program needs which precipitated the request. For programs with relatively stable patterns, the delay and frustration of purpose involved may interfere with efficiency but it is not catastrophic.

This study recommends a basically new way of delivering services and will call for a continuous evaluation of program with shifting points of stress. During the next decade it will be extremely difficult to pinpoint the most profitable deployment of resources. Traditionally, new services seem to create new demand for service. Development of new facilities will change the way in which the existing ones were utilized. It is anticipated that the developing community mental health concept will drastically alter the Department's inpatient-outpatient ratio. To accommodate to these patterns of change, it is recommended that the Department of Mental Health be authorized to submit its budget on a regional basis, rather than on the present institutional format. Budget requests should continue to be on a line item basis.

It is further recommended that the regional administrator, subject to the approval of the regional mental health committee and the Commissioner of Mental Health, be authorized to transfer items within line without further administrative approval. This budget approach is not unique and is clearly appropriate under present state fiscal controls. The Department of Public Health, through its "Bureau Budgets," has had the requested transfer authority for some time. The regional budgeting concept seeks this limited freedom on a geographical rather than a functional basis. Such flexibility is essential to the orderly development of the community mental health program in Massachusetts.

Regional Personnel Controls

Similarly the transferring of certain personnel controls from the central office of the Department of Mental Health to the region is recommended. Again, the purpose is to facilitate the necessary personnel transactions and to relate them closely to the service units.

Table of Organization

Regions will vary greatly in the number of people they serve and in the number of their component units. It is therefore difficult to project, with accuracy, a table of organization for regional administration.

Regional Mental Health Director

This person should develop, administer, integrate, coordinate and evaluate the comprehensive mental health programs of the region. The regional mental health director should be a person with wide knowledge of the many parameters of mental health, with an understanding of social system functioning and with an appreciation of the complexities of community organization and development. He should also be knowledgeable in the field of administration and possess administrative skills. Thus, he might be a psychiatrist, psychologist, social worker, educator, medical sociologist, public health nurse or public health physician. These skills in community mental health planning and service are relatively new and cut across many familiar disciplines and technical competences. An open policy will mean that different communities will have different kinds of key personnel, different kinds of agency involvement and different kinds of programs; an objective strongly recommended by many experts in this field.

As the delegate of the Assistant Commissioner for Community Programs, he should exercise supervisory authority in relation to the maintenance of personnel and program standards and should administratively adjudicate operational disputes that may arise between the component local units of the regional program. For the next 10 years, he will be exclusively involved in program development. He should have special responsibility for the preparation of the regional budget. Under his direction, the regional office should provide appropriate staff service to the region and should be responsible for the administrative coordination of all court clinic programs in the area. He should meet regularly with a committee composed of community mental health center directors. Finally, he should maintain close liaison with the staff specialists of the Department of Mental Health and with the Assistant Commissioner for Community Programs under whose supervision he should administer the regional program.

The regional staff should include:

A Regional Business Agent

This person should maintain liaison with the office of the Assistant Commissioner for Administrative Services and with the business agents of the community programs and institutions regarding purchasing and other fiscal problems within the region.

A Regional Director of Legal Medicine

This person should be responsible to the regional director for the supervision of the regional court clinic programs.

Community Organization, Health Education and Public Information Specialists

These people should provide appropriate direct services for the regional office and provide direct and consultative services to the local community units.

Administration of Local Programs

In other sections, this report described some of the functions and listed staff needs of a community mental health program. The degree of program autonomy to be established at the local level needs examination. As with the regions, there are definite limitations to the possibility of accurately projecting a table of organization applicable throughout the system until more experience about the programs themselves is available. Therefore, observations regarding the key

administrative posts in the community programs will be limited.

Executive Director and Medical Director

While there is a shortage of all disciplines of community oriented mental health professionals available to direct community mental health programs, the shortage is particularly acute among psychiatrists. However, it has been recognized that the medical practitioner may have particular strengths in maintaining the community and professional relationships so vital to this type of program. Clearly, there are administrative functions of a medical nature. Equally evident, there are administrative tasks which do not require medical knowledge or background.

A sharing of responsibility between medical and nonmedical community mental health administrative personnel is the obvious solution. Several models of hospital and program administration have been examined. It is recommended that community programs be administered through an executive director and a medical director, each with clearly defined areas of responsibility. Either of these roles could be designated the senior program administrator possessing ultimate local authority. Both options certainly should be tried in some of the earlier programs to determine the strengths and weaknesses of each. Either model could be compatible with civil service and additional state administrative requirements.

Recommendations have been made relative to the administrative structure of the Department of Mental Health, from central office to local community program. As with other recommendations in the report, it must be remembered that we are dealing with new concepts of programming. Therefore, our suggestions are starting points, not final answers. As the community mental health programs evolve, unanticipated problems will arise and some that are expected may not materialize. An administrative structure is of value only to the extent that it facilitates the execution of the organization's functions. This can only be tested in the light of experience. It is suggested that the Commissioner of Mental Health and his associates make use of all available alternative operational models, subject them to scrutiny and evaluation and alter them to meet the needs of the program.

CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH

Background

For decades, private citizens in America have been concerned about the problems of people in need. The roots of such concern run deep into America's history and have developed into a highly complex system of voluntary health and social welfare organizations to provide services to those in need. Rapid industrial and technological developments produced in their wake overwhelming economic and social problems which the voluntary system was unable to solve. The entrance and developing role of government in these concerns has steadily increased. Two major phenomena were the creation and expansion of the federal Social Security System and the current war against poverty—both massive programs. Many consequences can be attributed to these parallel and related developments. Chief among them is the perennial issue, "What should be the relationship between voluntary and governmental efforts to promote the general welfare for ourselves and our posterity?"

Any real understanding of current issues and developments in the mental health field can be achieved only from broad and historical perspective. In addition, the planning and implementation of broad and inclusive mental health programs must consider the multiple and constantly changing factors impinging upon all parts of the society. Failure to recognize economic or political feasibility, current community climate and administrative or professional imperatives results in a narrow viewpoint not likely to solve problems.

The idea of citizen volunteers, community involvement, and local participation in the shaping and operating of public service programs is not new. Public welfare boards, public health boards, public school committees and urban renewal programs attest to the validity of this concept. Despite the many problems influencing the effectiveness of citizen involvement in these various programs, the basic idea has gained consensus. In this respect a sharp contrast can be noted between the Social Security program and the current Anti-Poverty Program. Thirty years ago insistence upon participation by public welfare recipients in determining the policy and operations of the Social Security program would have met with almost complete resistance, if considered at all. How can such a sharp difference in community climate be understood unless it is first cast in historical perspective and then considered more specifically within the appropriate philosophical, economic, political and social contexts?

Mental health programming in America is now on the brink of major nationwide change. Primary impetus for such change derives from the federal government. Implications for existing programs, governmental and non-governmental, are great. Developing a viable role for citizen involvement is equally far-reaching, controversial and difficult to formulate. This was, in fact, one of the most difficult problems faced by the Massachusetts Mental Health Planning Project as it considered and planned for a comprehensive program.

Working Together

Experiences of the Planning Project revealed considerable misunderstanding about the concept of the comprehensive community mental health program. For some, it was simply a further proliferation of the existing facilities of hospitals, outpatient clinic services and rehabilitation services. For others, it meant major changes in the administrative structure of existing services to provide a more efficient distribution and operation of services. Actually, a community mental health program is both of these, and much more.

As conceived and projected, programs aim at providing total mental health services to meet the total needs of the community. The idea means considerably more than a complex of traditional psychiatric services. A basic element of the concept is the availability of a continuum of appropriate services to the patient and his family in/or as close to his home as possible. This may mean reaching the patient in the community early enough to avoid hospitalization, treating him at home on an outpatient basis or providing consultation to a community resource which in turn provides help.

If the patient is hospitalized, it may mean providing the variety and quality of services to enable his early return to the community such as day care, night care, foster care or a halfway house. It may mean some combination of follow-up services to insure his remaining in the community once he is released such as rehabilitation service and assistance in obtaining and keeping a job.

These are only a few of the functions of a comprehensive program which imply a dynamic interaction between the mental health center and the local community in behalf of the patient and his family. It becomes apparent immediately that the traditional psychiatric clinic team in the mental health center cannot achieve these functions alone. The support, cooperation, coordination and integration of total community resources are needed if the concept of a comprehensive community program is to be carried out effectively.

The program, therefore, means more than the center, or state-supported facilities. The total range of services organized by the community out of its concern for the welfare of its members is included. A mental health center is only one part of the program.

Citizen Participation in Massachusetts

Examination of existing functions and structures of Massachusetts citizens in mental health programs operated by the Massachusetts Department of Mental Health might be useful in understanding the problem.

Citizens in Massachusetts interested in mental health have contributed time, energy and talents without compensation in at least two major ways. First, as members of a board of trustees of state hospitals, board members of community clinics or as partici-

pants in formal mental health associations. Secondly, they have participated, in vast numbers, directly and indirectly, on behalf of the patient population in hospitals and clinics. In this discussion, we are concerned primarily with the former category.

Trustees The present trustee system is a remnant of earlier state efforts in the mental hospital field when no statewide system existed. Presumably as each installation was created it was provided with a board of trustees, appointed by the Governor, to act as the overseers. Once appointed, their policy function was limited to advising and selecting a superintendent from a list of three candidates submitted by the Commissioner of Mental Health. However, they could not remove the appointee without Department approval. Currently they have relatively little to do in their trustee role insofar as the welfare of the patient or the development of an effective hospital-local community relationship is concerned since they frequently reside at a considerable distance from the hospital.

Over the years the trustee group has emerged as a political entity appointed by the Governor. From an administrative point of view, the trustee arrangement seems to have emerged as an anachronism. How can we retain those individuals who have a valuable contribution to make for a new system, and yet abolish the structure which has outlived its usefulness? How can the Governor's appointive prerogative be retained, but on a more appropriate basis?

Board Members of Community Clinics The Division of Mental Hygiene of the Department of Mental Health, in developing its network of community clinics, created as community partners area mental health associations (often confused with the statewide voluntary associations). These organizations, comprising local leaders, serve as over-all advisory boards of the jointly-sponsored clinics or centers.

Ultimate responsibility for the care and treatment of patients served rests with a physician. The director is a medical person, and the organization usually has a professional advisory committee which includes medical representation. Partnership arrangements between the areas and the Department of Mental Health are informal agreements without contracts. Professional staff is usually employed by the central office of the Department of Mental Health, while the clerical staff, housing and equipment is provided by the local area. While such an arrangement seems to work satisfactorily in many instances, there are limitations and problems as far as a clearly defined role for the citizen board or association is concerned. Goals, as well as the balance of power in the "partnership," vary considerably from one area or community to another. Decisions regarding policy and program are influenced by a variety of factors at the local and/or state level and are often unrelated to the needs and resources of the area or the patient population.

Mental Health Associations The Massachusetts Association for Mental Health, a statewide voluntary organization with local affiliates in various areas and communities throughout the state, is another existing structure. Historically, this organization has been concerned primarily with the improved care and treatment of the mentally ill. While the basic role and function of this broad citizen's movement has remained essentially the same, its structure, program focus and activities have undergone considerable change over the years and vary from area to area in Massachusetts. Controversial issues and problems have been related to matters such as the operation of clinics, local-state relationships, financing, program and staffing. Factors affecting these variations included changes in leadership at the state level, changing relations with the state mental health authority, changes in program of the state authority and differences in leadership, interest and emphasis at the local level.

An especially knotty problem is reflected in the fact that the local mental health group in some areas is related organizationally to both, the Division of Mental Hygiene and the Massachusetts Association for Mental Health. Consequently, problems expressed at the local level are frequently reflections of problems and processes occurring at the state level. This further compounds an already complex situation and often creates a most untenable position for the representatives of the local community who are primarily concerned with their local area.

As one might expect, these developments have not occurred in any orderly, systematic fashion but have evolved somewhat erratically as local, state and national forces and organizations have interacted, both vertically and horizontally. As a consequence, the role and function of the citizen volunteer, inextricably interwoven with these structural arrangements and interactions, has emerged in an inconsistent way.

Generally, active and effective volunteer citizen participation in the mental health program is endorsed, sought and available from many quarters in Massachusetts. However, a consistent, adequate or appropriate set of structures to make use of the vast array of interested and talented citizens in behalf of the mentally and emotionally ill in a way which would produce effective coordination of the area does not appear to exist at the present time. Among the variety of existing settings and groups, there are many desirable features and dedicated volunteers which can and should be retained, developed and supplemented to achieve improved services and facilities.

Valuable contributions made by the statewide and the local voluntary mental health associations in stimulating community interest toward the development of community mental health services are fully recognized. Thoughtful attention must now be given to the reformulation of functions and activities of these important organizations as they become integrated into the new service-related structures.

Models for Citizen Participation

A variety of possible functions, roles and structures for the participation of citizens in the proposed comprehensive community mental health program in Massachusetts were considered. Two opposing points of view were expressed:

- A minority view asserted that the programs should be decentralized, locally funded to a considerable degree, given fiscal autonomy, and controlled by local communities as autonomous units.

- The majority viewed the community mental health program as largely state-supported and operated with a maximum of citizen involvement within those limits.

A basic issue underlying these views concerned the statutory-administrative framework within which the programs should operate. The minority position urged that the mental health program should be controlled by the local community through a mental health service act, similar to those enacted in New York and California. Such an arrangement would give the local mental health board the power to receive funds and determine how they should be spent and the responsibility for determining policy and operations for the local program. Basic decision-making would emanate from the local board. In this instance, decentralization would mean placing responsibility at the local level for the administration of autonomous units.

The rationale implies that without such a locus of power the community would have no real authority or responsibility. This fact would tend to vitiate local interest and enthusiasm for the program and discourage wide citizen support and participation.

Complete fiscal and policy control in the hands of local communities represents a drastic departure from the present arrangements and raises a number of crucial questions. What is its political and economic feasibility? How would total coverage of the state (a federal requirement) be assured? How would coordination be enhanced? How would an equitable distribution of resources among the "have" and "have not" communities be assured? What would happen to the state hospitals? How would political hazards, lay-professional tensions and other consequences be avoided?

Another point of view is reflected in the model held by a number of influential professionals which provides no meaningful opportunity for citizen participation. Planning, development and operation of the program would be in the hands of professionals. The rationale is that the tasks to be performed are of a technical/professional nature and citizens would only "get in the way." Collaboration between professionals and lay citizens represents a waste of valuable professional time and energy.

Between these two disparate points of view lies a third, representing a majority opinion. Parts of the community mental health program are government-supported and emanate essentially from the State Department of Mental Health. Final authority for these parts of the total program is necessarily vested in the Commissioner of Mental Health. This position is reflected in the model for citizen participation adopted by the Massachusetts Mental Health Planning Project. In essence, it provides for the establishment of local, regional and state level citizen groups, organized as semi-public bodies with representation from a wide variety of community interests. They are primarily advisory groups possessing the combined strong points of the existing state hospital trustee and clinic boards. The model is based on three assumptions:

- There is a need for a system in which the patient and his family are assured a coordinated set of services operating in their behalf.
- The comprehensive community mental health program is an effective way of accomplishing this goal.
- An administrative structure must exist, or be developed, which will enhance the program.

Recommendations for new administrative arrangements within the central office of the Department and a new set of regional administrative structures would decentralize policy making, planning, and program operations, as well as major portions of the budgeting process. These innovations place maximum responsibility at the regional and local levels.

The following models of citizen participation in the Department of Mental Health programs are designed to parallel and be integrated with the Department's new administrative arrangements. Plans reflect the political and economic feasibility while also serving to support the community based nature of the program. The models provide for the creation of a new system of formally organized citizen groups associated with the state-supported mental health services at the area, regional and state levels. In essence the citizen groups serve as a link between the various geographical communities and the administrative units of the state programs. Such a liaison system can aid in providing better service to the patient and to the community.

This new system of citizen groups should be established as early as possible in order to maintain and increase the high level of statewide citizen involvement developed to date by the Department of Mental Health, the Massachusetts Association for Mental Health and, more recently by the Massachusetts Mental Health Planning Project.

In addition, the new system should eventually supplant the existing state hospital boards of trustees and other Department of Mental Health affiliated citizen organizations. Every effort should be made to retain those citizens who have demonstrated an active concern with mental health problems and programs. In any event, the role for citizens must provide satisfaction to those involved and yet be directed toward the enhancement of coordinated services for patients, their families and the community.

Community Mental Health Board

Each of the 37 community mental health area centers should have a community mental health board.

Functions To exercise the right of prior approval of the Department of Mental Health's nomination for the center's executive director and medical director.

To identify local needs, issues and problems relevant to the direct and indirect services of the center, and to communicate this information to the director of the center.

To recommend to the director of the center appropriate policy and program priorities for the center.

To serve as liaison between the local community(ies) and the center.

To review the center's annual budget request.

To maintain formal liaison between the center and contiguous centers through official representation on the regional committee.

To select representatives to the regional mental health committees.

Membership Each board should consist of 30 members. Members should live or work in the area served by the center and each city or town within the area should be represented.

Membership of the board should include representatives from among the district medical society, local government, community welfare councils, mental health associations, public health, public welfare, schools, clergy, labor, industry, legislators, rehabilitation, corrections, civic, social, fraternal and other groups and individuals who have an interest in the programs of the several communities. Special efforts should be made to include those unaffiliated persons in the community who traditionally have been overlooked in the past. The director should be an ex-officio member.

Members should serve rotating terms of three years, except the first board which should serve equally divided staggered terms of three, two, and one years. No member should serve more than two consecutive full three-year terms.

Appointment Initial appointment to the board should be made by a selection committee convened by the Commissioner of Mental Health which should contain at least nine members.

Nominating Committee The selection committee should be organized by and composed of representatives of local government, community council(s), mental health association(s), medical society, Chamber of Commerce, organized labor and other interested groups and citizens in the community. Thereafter, the ongoing board should name its own nominating committee.

Meetings The local board should hold regular monthly meetings during the year except during the summer and should submit annual reports to the regional committee and the Commissioner.

Appeal The board should have the right to appeal to the regional director, the regional committee, the state council and the Commissioner in that order and as it may deem necessary.

Staff The board should have professional and administrative assistance from the center staff in the furtherance of its assigned responsibilities as listed above.

Funds Boards, as semi-public groups, could receive and expend voluntary and/or public funds.

Regional Mental Health Committee

Each of the six regions should have a regional mental health committee.

Functions To participate with the Department of Mental Health in the selection or removal of the regional director.

To review and recommend policy, program and priorities for the region, and to transmit its recommendations to the regional director.

To serve as liaison between the several local center boards, state council and the Department of Mental Health.

To select representatives to the state mental health council.

To review and approve the annual budget of the region and to ratify changes in the budget.

To assist the regional director in coordinating related programs in the region.

To hear appeals from other bodies.

Membership Each regional committee should consist of 30 members, who should live or work in the region.

Ten members of the committee should be appointed directly by the Governor. At least four of the following professions should be represented in the Governor's selection: medicine, psychology, social work, nursing, occupational therapy, law, rehabilitation, education and theology. The regional director should be an ex-officio member.

Members should serve rotating terms of three years, except the first committee which should serve equally divided, staggered terms of three, two and one years.

Representation At least two members of the committee should be elected from each local board and be named by that board.

Meetings The committee should hold regular monthly meetings, except during the summer months, and should submit an annual report to the Commissioner of Mental Health.

Staff The committee should have professional and administrative assistance from the office of the regional director in the furtherance of its assigned responsibilities as listed above.

The State Mental Health Council

A state mental health council should be associated with the Department of Mental Health.

Functions To advise the Governor on the appointment of the Commissioner of Mental Health.

To advise the Commissioner on policy, program development and priorities for the state mental health program.

To serve as a liaison between the several regions and the Department of Mental Health.

To participate with the Department of Mental Health and regional and local groups, in the sponsorship of regularly scheduled public hearings throughout the state.

To review the annual budget request of the Department of Mental Health.

To submit annual and other reports to the Commissioner and the Governor.

To hear appeals from regional and local groups.

Membership Membership of the council should consist of 30 members, 15 of whom should be appointed by the Governor and 15 of whom should be elected in equal numbers from the regional committees on a rotating basis where numbers are uneven.

Seven of the Governor's appointees should be drawn, one each, from among the following categories: medicine, law, social work, public health, education, public administration, psychology, labor, industry and the clergy.

The term of each member of the council should be for three years, provided that of the members first appointed and elected, ten should be appointed for a term of three years, ten for a term of two years and

ten for a term of one year. Vacancies should be filled for unexpired terms in the same manner as original appointments.

The Voluntary Association

Voluntary mental health associations have been referred to frequently throughout this report. The statewide association, as well as the network of local affiliates, has played a major role in the development of community mental health efforts in Massachusetts. Proposed new administrative arrangements and new roles and structures for citizen participation within the Department of Mental Health's comprehensive community programs pose special issues and problems for the existing network of voluntary associations. These issues reflect the need for a review or reclarification of the role of the association.

In view of proposed plans for comprehensive community mental health programs, several major functions for associations emerge as crucial and appropriate, and yet quite separate from those planned for the Department of Mental Health, local boards, regional committees and the state council.

Briefly, functions of the voluntary mental associations include:

- The development of community education activities, including public information about mental health and illness, community resources and facilities.
- Continued legislative support and social action at the local, state and federal levels. Increased work with the various state and federal programs such as public welfare, anti-poverty and vocational rehabilitation is needed to insure their support, as well as coordination between these services and community mental health centers.
- Continued encouragement and support of research in the field of mental health.

These areas of need, briefly outlined, only serve to highlight the fact that substantial gaps must be filled if the comprehensive community mental health program is to be implemented. A wide range of creative opportunities exist for the voluntary associations to accomplish tasks for which they are uniquely suited. However, to take advantage of these opportunities there must be:

- A clear definition of goals and functions and a consistent plan of action.
- A set of sound and realistic financial arrangements.
- A close working relationship with the Department of Mental Health based on a mutual desire for total service to the community.
- A close working relationship with the local mental health centers and with programing at the regional level.

The Community Welfare Council

The network of citizen groups associated with the state-supported services at the area, regional and state levels has been described in detail. The need for reclarification of the role of the voluntary mental health association, working in conjunction with those groups has been presented briefly. There remains in addition to these structures, the need for a more generalized, locally based citizen organization which is concerned with over-all social and human needs.

Community welfare councils usually serve this function. Traditionally, they cut across the range of health, recreation and social welfare needs of the community. Councils plan and coordinate the variety of services designed to meet community needs. Currently, the community welfare council is the only formally organized group which receives community-wide sanction to fill this role. The voluntary mental health association and the proposed citizens groups associated with the Department of Mental Health's community mental health centers should be functionally related to the community welfare council in those areas where one exists.

TRAINING AND MANPOWER

Key Recommendations

35. Mental health training activities should be allocated additional funds amounting to not less than 2½% of the budget of the Department of Mental Health, to be administered through the Department.

36. Staff positions to administer training programs should be established in the central office of the Department of Mental Health.

37. To implement the preceding proposals, the Department of Mental Health should establish a manpower planning and training council to plan and develop training programs to meet the state's needs, both public and private.

38. Through the proposed training budget recommended, the state should initiate a program of training support through fellowships and provision for additional training faculty to accommodate an increased number of mental health professionals in training.

39. An immediate impetus to mental health manpower needs should be achieved through expansion of present university training programs in the mental health professions. Careful consideration should be given to the development of financial methods through which state funds may be expended to enlarge these programs.

40. To further increase manpower resources, additional funds should be allocated through the budget of the University of Massachusetts for the purpose of increasing the faculty members and toward providing greater graduate fellowship support to those professions related to mental health activities.

41. An increased emphasis should be placed on "cross-fertilization" within the curricula of traditional mental health professions.

42. Current training programs should be reexamined to determine whether or not they are appropriate.

43. A wide variety of professionals with interests in human behavior, such as sociologists, political scientists, educators, clergymen and lawyers, should be encouraged to participate in training, research and education in mental health problems along with the traditional mental health professions.

44. Universities and other training centers should provide leadership in the development of training programs for new professional roles and should continue to foster a flexible perspective, a sensitivity to changing community needs and a framework for modification and change in existing training programs in light of future conditions.

45. Universities and other training centers should provide a model of comprehensive services in the field of mental health.

46. A greater emphasis on new and imaginative patterns of support for the development and training of investigators in mental health and the behavioral sciences should be encouraged.

47. University representatives from among the mental health professions should initiate and organize a conference on training for administration in mental health programs to be conducted in the late spring or early fall of 1966.

48. Requirements for affiliating key community mental health centers and state institutions with those universities presently directing professional and scientific degree programs in the various mental health specialties and related fields should be fully explored by the Department of Mental Health.

49. Graduate and professional training programs at the University of Massachusetts should be expanded.

Department of Mental Health

The following 15 recommendations are directed to the Departmental of Mental Health, whose praiseworthy efforts in the face of, at times, overwhelming handicaps merit the implementation of these proposals.

50. The Department of Mental Health should revise job descriptions and grade and salary classifications of all mental health professional staff (nurses, occupational therapists, psychiatrists, psychologists, social workers).

51. There should be established within the Department of Mental Health the positions of Director of Training and Director of Recruitment as permanent staff members.

52. Legal procedures should be initiated by the Department of Mental Health and community support encouraged to work towards the repeal of Chapter 31, Section 6a, of the Massachusetts Civil Service Law. (This statute prohibits the establishment of educational requirements for positions governed by Civil Service except by specific action of the state legislature relative to each position.)

53. Every service and professional discipline in the Department of Mental Health, at the central office level, should take immediate steps to provide greater opportunities for inservice training, job development, retraining and refresher courses and institutes and educational leaves.

54. The proposed Directors of Training and Recruitment should develop plans to identify younger employees in the Department of Mental Health presently serving in unskilled or semi-skilled positions who might be academically talented and tempermentally suited for encouragement and support for further study and training to a professional or sub-professional level.

55. Mental health agencies which prohibit their professionals from engaging in consultation and private practice in the community should revise their administrative regulations to permit the fullest development and use of professional skills both within these agencies and in the larger community to which these agencies are ultimately responsible.

56. Future community mental health centers as well as those within existing public and private mental health enterprises, should make realistic appraisals and provisions for the adequate administrative, secretarial and technician needs of the professional staff.

57. Superintendents' roles should be reexamined and institutions should work towards a considerable increase in the employment of trained administrators.

58. Consultant fee schedules should be raised in the Department of Mental Health, through consultation and advice from the relevant professional associations in the state along with the state's office of Administration and Finance.

59. Present state regulations and laws which prohibit state employees on the faculty at the University of Massachusetts and other state colleges from receiving more than one salary check from the state should be revised to allow the Department of Mental Health to employ the needed services of these qualified professionals on a consulting part-time basis.

60. State regulations should be developed to permit the payment of a realistic hourly wage scale for specified part-time professional positions.

61. Civil service regulations should be revised to provide criteria for appointment on the basis of professional training and experience, without written examination, for psychologists, social workers, nurses and occupational therapists to positions in state service.

62. The previously recommended Directors of Recruitment and Training should work with professional associations, the Massachusetts Association for Mental Health and other related groups on a campaign to attract students to mental health careers.

63. Civil service and Division of Personnel regulations of the state should be changed (and laws revised, if necessary) to permit immediate job commitments to be made to qualified mental health professionals.

64. A regional conference on training and manpower should be convened.

Overwhelming Problems

Manpower problems in mental health planning for Massachusetts are best exemplified by one word —"need."

In every profession which has come under scrutiny—psychiatry, psychology, social work, nursing, occupational therapy and others—the conclusion seems warranted that we are not meeting present manpower needs. As the contemplated new developments in community mental health emerge, we will be in an even worse manpower plight ten years from now. The purpose of this report is to identify specific issues which seem apparent and to make recommendations for resolution of these issues.

Plans for mental health training and manpower personnel needs during the next ten years have been considered in the context of an evolutionary thrust in the scope and magnitude of the field of mental health which is of almost revolutionary dimensions. The scope includes both increased support by government on all levels from national to local and increased interest and concern by government for the upgrading of standards for services to people. It also includes increased support and increased assumption of responsibility by community organizations and agencies.

Both the problems of mental health and action towards their solution transcend the specific areas of responsibilities and competence of the mental health professions. Problems of poverty, housing, education, job training and of race relations all have important repercussions on mental health. However, a most significant aspect of the widened scope of mental health is the recognition of a strong sense of social responsibility for the whole community by both the professional caretaking disciplines and the institutions in which they function. This increased scope, which includes the total population and incorporates the public health point of view, enormously increases the magnitude of the field of mental health and of the problems of training and manpower.

An Example

Documentation of the state's needs for mental health manpower, just within the Department of Mental Health, is impressive. In the Department of Mental Health, there are 340 physicians holding positions

as psychiatrists in 18 state institutions and 30 mental health clinics. Of these, about 50% are graduates of foreign medical schools, and only an estimated 50, including 18 superintendents, are board qualified. The Department of Mental Health employs approximately 130 individuals who function as psychologists. However, only one-third of these hold the Ph.D. degree, considered by the profession as the minimum qualification. Only seven psychologists in the Department of Mental Health are certified by their national board in their specialty. In the field of social work, only about 50% of the workers in the Department of Mental Health institutions are professionally trained to the master's degree level and seven of the 18 institutions have no professionally trained social worker on their staff. Of the 117 positions for head occupational therapist and occupational therapist in the Department of Mental Health, only 34 employees have been professionally trained. Furthermore, five institutions have no professionally trained occupational therapists.

Expansion of Training

Implications for training and manpower are manifold. A prime need is to produce many more trained personnel than are now being graduated from all facilities. A view of current and future production of mental health manpower presents a rather grim picture. Postponing for a moment the long view on needs for new and emerging skills related to future community mental health programs, the immediate situation regarding present professional manpower requirements warrants the conclusion that a massive bottleneck exists in production in the form of our major training stations—our universities. Our universities today, not only in Massachusetts but throughout the country, are not graduating a sufficient number of professionals to fill job vacancies. They are turning away literally hundreds of qualified candidates for graduate and professional training because of lack of faculty, space and training fellowship support. This applies to every professional field, at both the collegiate and graduate level. Ph.D. programs in clinical and counseling psychology at Boston University and the University of Massachusetts are rejecting literally hundreds of applicants annually for graduate education. There is no room for these students in already overburdened training programs. Similar situations hold true for social work and occupational therapy. Psychiatry, which fares better in Boston than elsewhere in the country, is attracting medical students into psychiatric training. However, this still represents a minority among medical training specialties and is inhibited in further development of training across medical specialties because of generally lower priorities among medical school allocations, faculty, space and "hard money" obligations.

To push through this bottleneck which constricts the expansion of manpower resources in the mental health professions, choices must be made between establishing new university and training centers or expanding existing ones. Both these routes are possible. While it would take several years to reach fruition, there are several universities in Massachusetts with potential resources and interests which could start new university training programs for mental health.

In relation to expansion of existing facilities, universities and training centers cannot and will not enlarge professional training opportunities without the means with which to do it properly. There is no cut-rate nurse, occupational therapist, psychiatrist, psychologist or social worker. To train these people takes scarce faculty time and costly university facilities. Universities are not reluctant to meet these challenges of community service, provided they are given the means to do so. The most striking example of this is seen in the participation of Massachusetts institutions in the National Institute of Mental Health Training Grant Program for 1964. Massachusetts ranks as the state receiving the highest number of graduate mental health trainee stipends in relation to population, and fourth (behind New York, California and Pennsylvania), in absolute numbers of stipends (618). Furthermore, Massachusetts ranked third in the nation for amounts of National Institute of Mental Health training funds awarded in fiscal year 1964 ($5,651,-829) and two of its universities (Boston University and Harvard University) were among the ten institutions receiving the largest mental health training awards in the country. Data developed by the National Institute of Mental Health survey support their conclusion that "three of every five former trainees find employment in the region of their last National Institute of Mental Health training." Massachusetts is first among all the states in the relative concentration of former National Institute of Mental Health trainees employed in relation to population in 1962.

The most appropriate program for enlarging the pool of trained manpower for mental health services is a pluralistic one. It involves cooperative participation from both private universities and private training agencies along with state financial support and planning. This approach runs contrary to the present constitutional principle in this state prohibiting the use of public funds for private purposes. Therefore, recommendations had to be tailored to accommodate this complex constitutional barrier.

Recommendations

35. Mental health training activities should be allocated additional funds amounting to not less than 2½% of the budget of the Department of Mental Health, to be administered through the Department.

36. Staff positions to administer training programs should be established in the central office of the Department of Mental Health.

37. To implement the preceding proposals, the Department of Mental Health should establish a manpower planning and training council to plan and develop training programs to meet the state's needs, both public and private.

Council members should include representatives from the Department of Mental Health, from universities, from federal, state, and private agencies, from private training centers and from respective professional associations in order to implement current practices, standards, needs and goals as well as to build in provisions for future manpower requirements.

Careful consideration must be given to the development of financing mechanisms through which public funds may be expended in the development and

training programs located in private training centers in Massachusetts. A possible approach, within constitutional limits, may be a contract-for-service arrangement or a combination of tuition and stipend grants.

38. Through the proposed training budget recommended, the state should initiate a program of training support through fellowships and provision for additional training faculty to accommodate an increased number of mental health professionals in training.

39. An immediate impetus to mental health manpower needs should be achieved through expansion of present university training programs in the mental health professions. Careful consideration should be given to the development of financial methods through which state funds may be expended to enlarge these programs.

40. To further increase manpower resources, additional funds should be allocated through the budget of the University of Massachusetts for the purpose of increasing the faculty members and toward providing greater graduate fellowship support to those professions related to mental health activities.

Modification of Training

A second major need is to modify or supplement current training programs. Modifications should reflect the types of institutions in which graduates will be practicing and the nature of the functions and responsibilities which students will be expected to assume. It is possible to envisage two such institutions which will likely play an increasingly dominant role in the next decade, the community mental health center and the all-purpose community center. The services of both are more likely to be oriented toward prevention and coordination with other facilities than toward the traditional individual service facilities of the past. Future graduates of training programs will require additional knowledge and skills in public health and in community organization in order to function in these institutions. At the same time, new graduates must not sacrifice the specific hard core of knowledge and competence which is the esssence of each of the professions.

Training programs might be described as the development of knowledge and competencies in relevant basic sciences and in specific practices and techniques. Graduate and professional students should be exposed early and frequently to contact with personnel and methods from allied professions to obtain an understanding of other contributions to mental health activities. Initiative for change from traditional roles must come from within the participating trainee-student and from training program curricula. Possibly, early modification of training and reexamination of selection criteria in admission procedures to graduate and professional schools might be required. Innovation in training and teaching should be encouraged, with experimentation and pilot projects viewed as major means of developing new approaches.

Recommendations

41. An increased emphasis should be placed on "cross-fertilization" within the curricula of traditional mental health professions. Representatives from other professional groups should be involved in training mental health workers.

42. Current training programs should be reexamined to determine whether or not they are appropriate.

Although the development of training programs for new and emerging needs is envisioned, programs should also be designed to train persons with the perspective and skills necessary to cope with certain defined problems and crisis areas.

New Professional Roles

A third major implication for training and manpower planning is the possibility of the emergence of a new type of mental health professional. It would be presumptuous to attempt a description of this presently non-existent individual or to present a blueprint for his training at this time. However, the implications for change in the field of mental health dictate the need for providing the climate necessary for the emergence of this role. A commitment to innovation and experimentation on the part of training centers and the broad involvement of others not usually identified with mental health roles would seem to be prerequisites for this purpose.

Recommendations

43. A wide variety of professionals with interests in human behavior, such as sociologists, political scientists, educators, clergymen and lawyers should be encouraged to participate in training, research and education in mental health problems along with the traditional mental health professions.

44. Universities and other training centers should provide leadership in the development of training programs for new professional roles and should continue to foster a flexible perspective, a sensitivity to changing community needs, and a framework for modification and change in existing training programs in light of future conditions.

Overlapping Functions

All of the professions have a common core of competency in addition to the areas of specific skills that differentiate them. That common core is the shared knowledge of human beings and their functioning in society. Because of this, there is an inevitable overlap of functions. It is proposed that such activities as psychotherapy, counseling and casework be viewed in terms of appropriate professional standards, knowledge, and competence rather than in purely jurisdictional terms. Developments toward a common core of knowledge and shared professional techniques tend to blur the formerly clearcut identities among the different professions. Intensive communication in training and in practice should tend to reduce intramural misunderstanding among professionals. To quote a sub-committee report in this regard, "In caring for the patient, no profession can go it alone, and greater interchangeability of function among professions involved in the mental health field must be recognized."

Recommendation

45. Universities and other training centers should provide a model of comprehensive services in the field of mental health.

Within this model, the students of medicine, nursing, psychiatry, psychology, social work and

others should be brought together to develop their contributions, to communicate and to work together.

Broadening the Research Base

Our knowledge of human behavior must be expanded through continued encouragement and vigorous support of investigators within all the life sciences. It is only through broadening our understanding of individual and group behavior that it will be possible to develop and evaluate new treatment methods for the problems of mental health and illness.

Recommendation

46. A greater emphasis on new and imaginative patterns of support for the development and training of investigators in mental health and the behavioral sciences should be encouraged.

Biology, biochemistry, social science, operations research and systems analysis are some of the fields that should be included.

Administrators

To prepare qualified leaders to assume administrative responsibilities for the many burgeoning facilities is a sixth concern for training and manpower planning. Administrators can be developed in two ways—either as graduates of programs distinct from the professional programs or as graduates from existing professional training sequences. Future administrators of mental health programs will probably emerge from the professions since the base of knowledge provided by professional training is felt to be a prerequisite for the development of adequate perspective and understanding. Present and future needs require that the professions provide more adequate preparation for administrative responsibilities either through basic training or through advanced programs. It may well be that such advanced training is best placed in an interprofessional setting rather than from within an individual discipline. The seriousness of the need for topflight administrators who will shape future mental health programs and the present lack of specific proposals form the basis for the following recommendation.

Recommendation

47. University representatives from among the mental health professions should initiate and organize a conference on training for administration in mental health programs to be conducted in the late spring or early fall of 1966.

The goal of the conference would be to identify the problems and to develop possible solutions in the training of administrators for leadership in mental health roles.

Enlarging Manpower Resources

It is obvious that traditional professions alone cannot cope with the needs for manpower. Many others will have to be trained. How will this be done? The major responsibility for the training of personnel in other professions such as law, education and the clergy will rest initially upon the institutions and personnel from the traditional mental health professions. Many different types of personnel will have to be trained. There will be the need for increased planning for such training in collaboration with the groups involved. Professional trainers will need to be trained and retrained. Substantial manpower in the professions will have to be diverted to such activities if we are ever fully to develop the evolving mental health facilities for the fulfillment of their tasks.

Rather than the proposal of specific recommendations, this discussion is divided into four position statements pertaining to collaborating professional groups, supporting groups, the citizen and the special training needs of women.

Collaborating Professional Groups

A program should be developed for the training of collaborating professional groups such as physicians, teachers, ministers, lawyers, correction officers, public health nurses, rehabilitation counselors and personnel workers. Obviously, a cadre of well trained and interested mental health professionals should be available for teaching and consultation work with these groups.

Instruction and experience in consultation with collaborating professional groups should be included in the training of all psychiatric residents and should be seriously considered as part of the training program of clinical psychologists. This training should include an appreciation of the professional attitudes and practical problems of each of the collaborating professional groups. The necessity for proper timing and tact in communicating mental health principles without denigrating the importance of the principles should be emphasized. Undoubtedly, the individual training programs for psychiatric residents and psychologists would vary as to extent, order and content of this instruction and experience. Results of this phase of their training should be informative and valuable to the various training programs.

At present there are several programs in existence for advanced training in community psychiatry. Undoubtedly, similar new programs will be developed in the relatively near future. These programs include more than training in consultation for collaborating professional groups, although this phase of the training program is a crucial part. Strongly motivated and talented psychiatrists, psychologists, social workers and social scientists are the logical candidates for such training. How much training and experience should they have? How much work in individual psychotherapy should they have before entering training in community psychiatry? A careful appraisal of the efficacy of these programs will determine the answer.

Various programs are now being, or recently have been, conducted for the training of collaborating professional groups. These programs vary in intensity, in content, and in their basic aims not only among the various professional groups but among the programs designed for one or the other groups. It would be of considerable value if these programs were systematically reviewed and some attempt was made to appraise their effectiveness.

All programs will probably include training in the recognition of deviant behavior and in the understanding of external factors likely to activate emotional crises. However, these external factors will

vary depending upon whether they are seen by a teacher or a correctional official. The choice of a physician or a minister for assistance when someone is in emotional difficulties is determined by complex psychological and sociological forces. Accordingly, each professional group is confronted by quite different attitudes on the part of people who go to them. Each professional group brings to the problem their own unique attitudes about their role in the management of such situations. Therefore, training should be adapted to the needs and attitudes of the groups, should be flexible and experimental and should be frequently reevaluated.

Supporting Groups

Training for prevention, early detection and treatment of the behavior disorders requires an awareness of mental health problems among those working in physical and social welfare areas. Basic principles of psychology, psychiatry, sociology and social work should be introduced into the training curricula of a wide variety of assisting caregivers at an early stage of training.

Various mental health professions must take increasing responsibility for the training and the specific job roles of groups which assist them such as attendants, nurses aides, psychological examiners, social casework aides and occupational therapy aides. Training curricula, recruitment and job descriptions are three particular problems on which mental health professionals might concentrate.

A fundamental problem confronting all present and future mental health professions is the extent to which certain activities, usually reserved for professionals, could be performed satisfactorily by assisting groups. A careful and critical review of their own activities should be made by professionals. Consideration should be given to areas of work that might be delegated to assisting technicians as a required step towards progress in solving the manpower shortage and training problem.

The Citizen

Contributions to mental health care by private citizens through their participation in mental health boards, associations and in volunteer work in institutions and clinics are immeasurable. Their dedication to these humanitarian efforts has been a major support to the mental health program in this state.

Mental health professionals should continue to encourage an active, informed and dedicated board and advisory committee group of citizens who can take strong leadership in community mental health programs. With support from a skilled professional group, they can serve as missionaries for the cause with their zeal and information coming from their agency affiliation, but their concern spreading to all parts of the mental health field.

Mental health professionals should actively participate in the recruitment and training of volunteers to work in our mental hospitals and centers. The changing mental hospital in a changing society can profit from an army of friends who go back and forth between institution and community and bring goodwill both ways.

Increasing understanding among the citizens of the availability and methods for securing psychiatric treatment, of the means for prevention of mental illness and of the organization of care for the mentally ill should be a continuous responsibility of mental health professionals. There should be a planned program of enlightenment of the community by mental health professionals working through newspapers, radio, schools and all publicity media. Mental health professionals should free themselves to mingle with all kinds of social, community and professional groups as informal and formal messengers of the doctrine of good mental health.

Special Training Needs of Women

Womanpower is an important present and potential labor source for the mental health professions. Today many mental health workers are women. Women are to be found in all fields, but especially in nursing, social work, clinical psychology, occupational therapy, school guidance and in volunteer mental health activities. Contributions that women have already made to the mental health field are small compared to what they can offer if appropriate adjustments are made to meet their special educational needs.

Special training and educational needs of women are organized within the dimension of time. Training programs for all the mental health professions should be flexible enough to permit the motivated and able woman to start and continue her training and eventually make all the contributions she can.

In particular, educational institutions need to reorganize many of their regulations and administrative practices to meet women's needs. Continuing educational opportunities, both credit and noncredit, should be available for their own alumnae and for women of the local community. Opportunities for mature women to return to the campus for mental health training should be developed through provisions for part-time study, admissions policy revisions, proficiency testing, establishment of bridging courses, the use of educational guidance services and the creation of special programs of training. These suggestions are all outlined in the report of the Education Committee of the President's Commission on the Status of Women.

In addition, professional organizations should have a standing committee on the needs of women in the profession such as the National Association of Social Workers committee for temporarily retired social workers.

Finally, special pilot programs for training or retraining of women in mental health areas should be more vigorously pursued. Three noteworthy examples are the National Institute of Mental Health program for the training of psychotherapists under Dr. Margaret J. Rioch's direction, the New York Medical College's residency program for women psychiatrists (which enables the married woman doctor to spend her summers with her children) and the Sarah Lawrence College—New York University School of Social Work program (which permits part-time social work training within commuting distance of a woman's home).

Manpower and University Affiliation

There is a concentration of professional mental health manpower in the metropolitan Boston area. About 73% of the Massachusetts members of the American Psychiatric Association and approximately 50% of the members of the Massachusetts Psychological Association work and live in the Boston area.

A reallocation of manpower resources cannot be accomplished by salary or status measures alone. Professional people work in areas which are professionally rewarding, where they can function as effective nurses, psychiatrists, psychologists, social workers or occupational therapists. It is well known that little "oases" exist throughout the state which attract certain professionals. In turn, the trainees go on to take leadership in the development of training, research and service opportunities elsewhere. These "oases" have one major common element regardless of the profession involved—the university relationship.

Recommendation

48. Requirements for affiliating key community mental health centers and state institutions with those universities presently directing professional and scientific degree programs in the various mental health specialties and related fields should be fully explored by the Department of Mental Health.

The vehicle through which the Department of Mental Health might develop this could be sections for Training and Recruitment, within the Division for Professional Services. These units of highly qualified professionals could assist in developing local leadership and partnerships throughout the state among state, university and public and private mental health agencies.

New Programs at the University of Massachusetts

The expansion of the University of Massachusetts will continue to be a potentially strong force in meeting training and manpower needs in Massachusetts. When universities establish graduate and professional training programs, they invariably attract many more professionals to their geographic area, well beyond the proportion involved in direct faculty responsibilities. "Oases" for future mental health manpower contributions can be envisaged in the immediate future through initiation of new university programs throughout the state and expansion of existing ones at the University of Massachusetts.

Recommendation

49. Graduate and professional training programs at the University of Massachusetts should be expanded.

Planning should be continued among Department of Mental Health representatives, professional association leaders, directors of existing graduate and professional training programs from universities within the state, and University of Massachusetts officials. The University of Massachusetts should establish graduate schools of nursing and social work, programs for collegiate training of occupational therapists and for expansion of present Ph.D. psychology training. Psychiatric training and services, along with new schools for social work and graduate nursing, could join the graduate programs in psychology in bringing needed manpower and services to the state.

Department of Mental Health

The following 15 recommendations are directed to the Department of Mental Health, whose praiseworthy efforts in the face of, at times, overwhelming handicaps merit the implementation of these proposals.

50. The Department of Mental Health should revise job descriptions and grade and salary classifications of all mental health professional staff (nurses, occupational therapists, psychiatrists, psychologists, social workers).

The proposed changes in the provision of mental health services requires a redefinition and a restructuring of the roles of professional personnel in the Department of Mental Health. This cannot be accomplished by a simple change of job titles, pay grades or numbers of personnel employed. Rather, a complex reorganization of roles and functions to fulfill several objectives is needed.

A greater variety of skills and a broader background of training will be required of our professionals if they are to be successful in the new tasks to be undertaken. Therefore, new position descriptions, more qualified personnel, higher professional standards and higher grade classifications for professional personnel will be required.

There is a need to provide for the continued employment of lesser-trained personnel to perform functions commensurate with their abilities. These junior associates should work under supervision to support and complement the work of their supervisors. Junior personnel should have opportunities for mobility through further training, promotion and reassignment to make a maximum contribution to the Department of Mental Health effort.

Another implication of reclassification relates to the conviction that obtaining high-level personnel for high-level roles should ultimately reduce turnover and recruitment problems. It also should provide the professional with rewarding achievements while furnishing more comprehensive mental health services to the citizens in the community.

Finally, adoption of the proposed reclassification procedures for the Department of Mental Health should greatly enhance affiliations with university training and research centers. This could result in improved mental health training, research, recruitment of professionals and program innovations. It could also result in a broader base of community participation in the mental health programs throughout the state.

51. There should be established within the Department of Mental Health the positions of Director of Training and Director of Recruitment as permanent staff members.

These persons should have the experience, status and initiative necessary to provide leadership in the development of training programs. State, private, and university settings should be related in coordinated approaches to child development, mental

retardation, the sociology of institutions, self-examination of the team concept, regional planning, evaluations of new technological methods and their application to the training of personnel, inservice training program development and similar activities.

52. Legal procedures should be initiated by the Department of Mental Health and community support encouraged to work towards the repeal of Chapter 31, Section 6a, of the Massachusetts Civil Service Law.

This statute prohibits the establishment of educational requirements for positions governed by Civil Service except by specific action of the state legislature relative to each position. Presently the law reads as follows:

> (Chapter 31, Section 6a Massachusetts General Laws) "Educational Requirements. No rule or regulation shall be made setting up educational requirements as a condition of taking a civil service examination except in respect to professional and other positions for which such requirements are expressly imposed by statute and to the extent of the requirements so imposed. Added St. 1935, c. 228."

53. Every service and professional discipline in the Department of Mental Health, at the central office level, should take immediate steps to provide greater opportunities for inservice training, job development, retraining and refresher courses, and institutes and educational leaves.

Shortages exist in practically all professional fields related to mental health. At the same time many dedicated individuals in the Department of Mental Health are stepping in to fill gaps created by professional shortages.

Specifically, the Department should implement continuing education opportunities. Many practices used in industry such as payment for college and professional courses taken by the staff, full salary reimbursements for time in studies, provisions for annual promotion and step increases while absent on educational leave should be considered. Upgrading of job classifications and salaries should be worked out well ahead of time to be awarded to those whose investments of energy, time and interest in additional studies result in the production of a more highly skilled contributor. It is suggested that plans for inservice training for all positions be developed by the central office staff of the Department of Mental Health with the advice and guidance of university and professional association leaders in the relevant groups.

54. The proposed Directors of Training and Recruitment should develop plans to identify younger employees in the Department of Mental Health presently serving in unskilled or semi-skilled positions who might be academically talented and temperamentally suited for encouragement and support for further study and training to a professional or sub-professional level.

Many nonprofessional employees within the Department of Mental Health might be capable of, and motivated for, greater contributions through additional training and education. As seen from personnel models presented in private industry, the identification, encouragement and support of an organization's own employees benefits morale among all personnel while it serves to recruit and use higher-level skills and ambitions previously unfilled.

Further, a system of rewards and promotions should be developed and implemented so these employees could qualify and benefit from professional training.

55. Mental health agencies which prohibit their professionals from engaging in consultation and private practice in the community should revise their administrative regulations to permit the fullest development and use of professional skills both within these agencies and in the larger community to which these agencies are ultimately responsible.

Some public and private mental health agencies, as well as the Department of Mental Health, restrict the activities of their professional personnel. Needed private and consulting services that these professionals are willing and able to provide are not available to the public or to other professional agencies. A historical basis for these administrative regulations exists, but it is apparent that professionals find themselves unable to develop and contribute in the fullest professional sense within the framework of these restrictions. This is frequently the case in the Veterans Administration where psychiatrists and nurses are prohibited from engaging in private practice outside of their regular tour of duty. It is indeed ironic and unreconcilable to continue to deny professional services to the community in the face of both present needs and future evolution of community mental health practices.

56. Future community mental health centers, as well as those within existing public and private mental health enterprises, should make realistic appraisals and provisions for adequate administrative, secretarial and technician needs of the professional staff.

Inadequate provisions for administrative, secretarial and technician support are widespread and directly affect the activities of many mental health professionals, particularly in the Department of Mental Health. The absence of supporting services results in professional manpower diversions to accomplish necessary administrative, secretarial and technician duties.

57. Superintendents' roles should be reexamined and institutions should work towards a considerable increase in the employment of trained administrators.

There is a tremendous loss of leadership opportunities among administrators of state and private institutions. Unrealistic expectations of personal responsibility and direct supervision over patient and personnel activities divert superintendents' energies and talents from innovative and future oriented plans and programs. Many examples of this are evident. State hospital superintendents are frequently involved and responsible for almost every detail of a patient's social, and economic behavior. If we expect state and private mental institution superintendents to be participant-leaders in a community-institution partnership, these superintendents need to be relieved of responsibilities which might be assumed by trained hos-

pital administrators, a pattern already familiar in general and mental hospitals.

58. Consultant fee schedules should be raised in the Department of Mental Health, through consultation and advice from the relevant professional associations in the state along with the state's office of Administration and Finance.

Involvement in the Department of Mental Health program developments by consultants from leading universities and other training and service agencies has been distinctly hampered by the totally unrealistic consultant fee schedule of the state. A fee of $15 or $25 which state agencies are permitted to offer a professor for a half-day to a full day's work is presently inadequate and inconsistent with consultant fees of other governmental agencies.

59. Present state regulations and laws which prohibit state employees on the faculty at the University of Massachusetts and other state colleges from receiving more than one salary check from the state should be revised to allow the Department of Mental Health to employ the needed services of these qualified professionals on a consulting part-time basis.

State regulations, at the present time, prohibit an employee of the state from accepting more than one state check in payment for his services. Therefore, this regulation restricts such professional employees as faculty at the University of Massachusetts from receiving payment for consulting services to the Department of Mental Health. This regulation denies to state agencies such as the Department of Mental Health opportunities to involve professional assistance in programs in the western portion of the state where manpower resources are particularly lacking.

60. State regulations should be developed to permit the payment of a realistic hourly wage scale for specified part-time professional positions.

Current state regulations discourage the employment of part-time professionals and other personnel because no provisions are available for paying realistic hourly salaries. Unless an employee is able to work half-time, no fringe benefits such as insurance, leave and retirement are available. Yet, the employee is not compensated for this. Since the base salary rate was originally low, the Department of Mental Health is unable to find professional people who are able to make the financial sacrifice though they are well qualified and willing to work for one or two days a week.

The consultation and advice of relevant professional associations in the state should be sought in determining payment schedules.

61. Civil service regulations should be revised to provide criteria for appointment on the basis of professional training and experience without written examinations for psychologists, social workers, nurses and occupational therapists to positions in state service.

Except for licensed or registered professions such as medicine and nursing, Massachusetts Civil Service regulations require that written examinations be taken by professionals for appointment to state positions. In the Department of Mental Health, this particularly affects psychologists, social workers, central office staff nurses and occupational therapists, whose qualifications are more adequately reflected through university degree programs and post graduate professional experience.

Unassembled examinations are used to qualify for federal Civil Service positions and are based on educational training and experience. Relevant professional associations should assist the Massachusetts Civil Service and other appropriate officials in the development of criteria for professional appointments. Federal regulations, where they dictate state selection procedures as criteria for granting monies to the state, should be altered to permit evaluation of professional qualifications based on training and experience.

62. The previously recommended Directors of Recruitment and Training should work with professional associations, the Massachusetts Association for Mental Health and other related groups on a campaign to attract students to mental health careers.

The mental health field is presently in competition with other professional and scientific fields for talented youngsters. Present numbers of new students entering psychiatric nursing, social work, psychiatry and occupational therapy are falling far behind population growth and expanding needs.

Programs such as the state's student summer stipend program and the social workers' summer recruitment "learning-earning" careers program should be further supported through additional state funds and cooperative efforts of state, public, and private agencies and associations. Talented high school and college students should be alerted to the rewards of mental health careers as part of a recruitment campaign.

63. Civil Service and Division of Personnel regulations of the state should be changed (and laws revised, if necessary) to permit immediate job commitments to be made to qualified mental health professionals.

The Boston area continues to hold high attraction for mental health professionals among private institutions. However, the attraction to Department of Mental Health positions is considerably impaired by the absence of any organized recruitment activities by either of the state's Divisions of Personnel or Civil Service. Other states, such as California and New York, publicize and recruit on a national scale by sending personnel teams to all regional and national meetings of relevant professional associations. At these meetings, recruitment personnel from other states are able to make immediate job offers to qualified professional personnel. Administrators of Massachusetts mental health programs are not permitted to make these commitments. Obviously, this places many of our state departments (Mental Health, Public Health, Correction, Welfare) at a distinct disadvantage in recruiting scarce professionals for vacant positions.

64. A regional conference on training and manpower should be convened.

Massachusetts, through the Department of Mental Health, should take the initiative in organizing a six state conference of the Commissioners of Mental Health, staff personnel and University representatives most directly concerned with the problems of training and mental health education. The conference should plan for cooperative action on mental health training needs in New England.

FINANCING OF MENTAL HEALTH PROGRAMS

Key Recommendations

65. Financial support for mental health programs should come from a variety of sources, both voluntary and governmental.

66. Financial support for increased mental health services dictates the need for third-party insurance organizations to expand their coverage of the costs of mental illness.

67. Community mental health services should continue to be offered under a variety of auspices, irrespective of the source of financing.

68. Based on current estimates, costs of staffing and administering a typical community mental health program should be approximately 1½ million dollars annually.

69. By 1975, when the community mental health program is fully implemented, this aspect of the Department of Mental Health's annual budget should be increased by about 40 million dollars.

Services Available to All

Certain basic resources must be available to all, not merely the destitute or well-to-do. Such an approach would make services equally available to all when intervention is diagnostically appropriate, not merely when the situation has deteriorated to the point that long-term custodial care is the only answer. Clearly, this type of program requires the joint financial participation of government at all levels, of voluntary philanthropy and the purchase of treatment on a fee-for-service basis through direct or third-party payment.

Table 1

PATIENTS RECEIVING PSYCHIATRIC CARE BY SOURCE OF FUNDS AND/OR BY AGENCY PROVIDING CARE
United States, 1956 and 1962†

Source of Funds and/or Agency Providing Care	*Patients Receiving Psychiatric Care*				*Percent Increase 1956 to 1962*
	1956		*1962*		
	Number	*Percent*	*Number*	*Percent*	
ALL SOURCES AND/OR PROVIDERS	2,607,248	100	3,197,164	100	23
Government	1,279,042	49	1,607,101	50	26
Federal (inpatient)	137,808	5	154,758	5	12
Veteran's Administration (VA)	111,635	4	124,022	4	11
Department of Health, Education, and Welfare (HEW)	15,413	1	15,577	1	1
Department of Defense	10,000	*	14,000	*	40
Department of Justice	760	*	1,159	*	53
State, county, and local	1,141,234	44	1,452,343	45	27
Publicly owned mental hospitals	731,234	28	787,343	24	8
Community mental health services (includes VA outpatient)	410,000	16	665,000	21	62
Private	1,328,206	51	1,590,063	50	20
General hospitals, psychiatric services	188,217	7	209,264	7	11
Privately owned mental hospitals	86,589	3	80,799	2	−7
Psychiatrists in full-time private practice	1,053,400	41	1,300,000	41	23

* Less than 0.5 percent.

† *Blue Cross Reports*, Blue Cross Association, Vol. II, Number 3, July-September, 1964.

N.B. These data do not include those individuals receiving care from nonpsychiatric resources, e.g., family agencies, visiting and public health nursing services and nonpsychiatric private practitioners.

How Services Have Been Financed

Data illustrated in Table 1 show a rather dramatic increase in recent years in the number of patients receiving psychiatric care. However, in the period, 1956-1962, there were no major changes in the proportions of patients cared for through the various funding sources. About one-half of all patients were cared for by privately funded agencies or practitioners and the other half through government resources, mostly state, county or local. One meaningful trend developed within this governmental category. By 1962, a higher proportion of patients were being treated through community mental health

services while a correspondingly smaller proportion were included in the publicly owned mental hospital category.

This changing emphasis was reflected in an analysis of the source of funds expended for psychiatric care during the same period (see Table 2). Overall, government funds continued to account for about three-quarters of the total spent for the care of the mentally ill, with state and local governments accounting for the bulk of these expenditures. Although expenditures were larger in all categories, the most marked increase was for community mental health services. In terms of total dollars expended, a higher proportion went for these services, largely outpatient, and a smaller proportion for publicly-owned mental hospital treatment.

Table 2

DIRECT EXPENDITURES FOR PSYCHIATRIC CARE BY SOURCE OF FUNDS AND/OR BY AGENCY PROVIDING CARE
United States, 1956 and 1962†

Source of Funds and/or Agency Providing Care	*Direct Expenditures (In Thousands of Dollars)*				*Percent Increase 1956 to 1962*
	1956		*1962*		
	Amount	*Percent*	*Amount*	*Percent*	
ALL SOURCES AND/OR PROVIDERS	1,223,869	100	1,990,174	100	63
Government	913,727	75	1,488,174	75	63
Federal (inpatient)	237,727	20	378,163	19	59
Veteran's Administration (VA)	198,200	17	314,303	16	59
Department of Health, Education, and Welfare (HEW)	23,027	2	37,171	2	61
Department of Defense	16,000	1	25,000	1	56
Department of Justice	500	*	1,689	*	238
State, county, and local	676,000	55	1,110,011	56	64
Publicly owned mental hospitals	649,000	53	1,010,616	51	56
Community mental health services (includes VA and Department of Defense outpatient)	27,000	2	99,395	5	268
Private	310,142	25	502,000	25	62
General hospitals, psychiatric services	54,000	4	88,000	4	63
Privately owned mental hospitals	77,064	6	154,000	8	100
Psychiatrists in full-time private practice	179,078	15	260,000	13	45

* Less than 0.5 percent.
† *Blue Cross Reports*, Blue Cross Association, Vol. II, Number 3, July-September, 1964.

It should be noted that while almost all financing sources increased mental health expenditures over the period 1956-1962, there were no appreciable changes in the proportions expended by each. It is anticipated, that as a result of community-based programs and the increasing use of tranquilizing drugs, large segments of the custodial inpatients from state hospital systems will move to outpatient facilities. These changes will require an accommodation within the systems which currently finance mental health care. This portion of the report is addressed to that issue.

Basic Assumptions

Before considering the issues, a frame of reference needs to be established. The discussion which follows arises from the following assumptions:

- There is a large sum of money now being expended from many sources to finance mental health care.
- There is a substantial unmet need for additional financing as substantiated by other sections of this report.
- The additional operating and capital funds needed probably will exceed the amount of tax fund, whether federal, state or local, which will be available for these purposes.
- It is equally unrealistic to expect traditional voluntary and charitable resources alone to provide these needed funds.
- State plans must provide for maximum flexibility. A method of expenditure of state-federal tax funds should be used to work most effectively in encouraging voluntary, additive financing of the mental health program, both operating and capital.
- Existing public welfare programs jointly financed with state and federal tax dollars, e.g., Medical Assistance to the Aged, often

exclude the mentally ill from coverage. Such exclusionary practices may require the development of different means of financing services and facilities for the indigent mentally ill.

- Decisions regarding allocation of funds for comprehensive community mental health programs should recognize the responsibility for supporting research, training programs and preventive services.
- Insofar as he is able to pay, the basic responsibility for meeting the cost of treatment rests with the individual, his family and private resources, including insurance.
- Present insurance coverage often is not sufficient to meet potential mental health needs of the great bulk of the citizenry.
- For any mental health program to be financed soundly, whether through insurance or other means, there must be an acceptable organization of the provision of services and this system should be subject to evaluation and control.

Voluntary Financing of Mental Health Care

Increasingly larger numbers of people are being identified as emotionally disturbed. The process of treatment is often lengthy and costly. It seems obvious that voluntary, nonprofit or philanthropic financing can never be sufficiently extensive to support the direct services and facilities needed by the emotionally disturbed population by themselves; let alone promote an environment conducive to mental health. Increased needs and rising costs suggest that, for the foreseeable future, voluntary financing will supply an even smaller share (though the absolute amount in dollars may continue to expand) of the funds for support of services and facilities in the mental health field. In turn, government at all levels will have to bear an increasing portion of the financial load.

However, private philanthropy continues to have significant responsibility for providing services and facilities for mental health at the local community level. These include the role of maintaining the community system of "services in being" under voluntary auspices in the health and welfare field. This essential resource includes skilled professional personnel, administrative knowledge, and years of service experience. In addition, voluntary programs have the role of emphasizing "high quality" in provision of service, thus offering a standard for emulation for emerging programs in mental health and the role of maintaining administrative and program flexibility so new service patterns can be developed.

The Physician in Mental Health Care

Generally and historically, the ultimate responsibility for the individual with mental illness has rested with the physician, often the psychiatrist. An increase in the number of psychiatrists is required as well as efforts to gain the maximum service from those available. Financial return is not the only factor in increasing the number of psychiatrists, but it is an important consideration.

Comprehensive mental health care will be carried out under a variety of organizational arrangements but the simplest and most traditional arrangement is the direct patient-physician pattern common to the private practice of medicine. For those unable to pay for services, the federal and state governments propose to bear the responsibility for obtaining adequate mental health care.

Among the factors which have led to increased use of private psychiatric care are increased knowledge regarding the treatment of mental illness, prepayment hospitalization plans, improved economic conditions, development of general hospital psychiatry and improved public attitudes toward mental illness. It is obvious that if more are able to be treated privately, fewer will require public money to pay for their care. The government-maintained hospitals have a continuing role, particularly for chronic mental illness and incurable personality and developmental disorders.

Prior to the last few years, hospitalization for mental illness was predominantly in hospitals maintained by the public. Psychiatry in general hospitals, while still new, seemed to establish one principal fact; the majority of acute mental illnesses can be short-term. Efforts should be made to evaluate the finding and the reasons for it.

Nationwide statistics suggest that as many psychiatric patients are now cared for in general hospital psychiatric services as in tax-supported hospitals. In general hospitals, the duration of stay has been reduced to an average of fourteen days which compares favorably to hospitalization for somatic illness and represents a great saving of time away from family, work and the community. This saving of time alone represents a vast economic benefit to the patient, the family, the employer and the community.

Psychiatric services in general hospitals should be encouraged in planning for comprehensive mental health care for financial as well as for therapeutic and sociological reasons.

The patient-physician-hopsital relationship has always been an important segment of patient care. Physicians also have a role as consultants to paramedical groups and agencies. Expanding government participation in community programs suggests that consideration must be given to the development of devices through which the government can compensate the physician for these services.

Financing of Mental Health Services in General Hospitals

General hospitals, as social institutions, are being asked by society to provide, or participate in providing, comprehensive mental health programs and facilities. This care is conceived to be a right rather than a privilege.

Society needs to finance general hospital mental health programs. A significant portion of those persons needing such programs are unable to finance their care directly or completely. Tax fund support is therefore needed. Funds very likely will not, and should not, provide completely the operating and capital funds needed. Voluntary financing should continue to be encouraged.

Financing of general hospital mental health programs should be subject to hospitals maintaining min-

imum standards, including compliance with the state plan, and standards for personnel, program and physical plant. Exceeding minimum standards should be encouraged. General hospitals meeting minimum standards for any mental health program, whether short or long-term, should be considered an appropriate setting for providing care.

Financing policies should permit general hospital initiative and creativity in the development, content and execution of mental health programs. To this end, financing policies should provide alternative sources and methods of financing and complete reimbursement for services purchased.

Third-Party Payment for Mental Health Care

In recent years, insurance companies have experimented with coverage for mental illness aimed at services in general hospitals, private mental hospitals and to a lesser extent at diagnostic services by physicians. To meet the resistance of those unwilling to pay skyrocketing premiums, various limitations have been tried. These include deductibles, coinsurance and the exclusion of many forms of mental health care. Development of community mental health centers under a variety of medical care structures will create an opportunity to experiment further with insurance plans.

The potential financial loss in prolonged mental illness is clearly beyond the means of most individuals and may deplete family resources. Insurance against unlimited liability becomes actuarially unsound and premiums pyramid to levels beyond ability to pay. Nor is the present arrangement of individual payment at less than cost (e.g., $6.95 per diem) a reasonable solution to the financial problems of long-term mental illness.

Increasing federal participation in financing community mental health programs has caused much concern in some quarters. It is important that future experimentation in insuring for the cost of mental illness be based on a recognition that the government must be involved because of the magnitude of the personal liability in prolonged care. Key to any meaningful plan is a clearly developed position which limits personal responsibility and defines public responsibility.

A position taken by Massachusetts Blue Cross-Blue Shield states that most of the cost of treating mental illness during its acute phase can be prepaid. Long-term treatment and custodial care do not lend themselves to the voluntary payment mechanism.

While prepayment has seemed feasible for inpatient care, the same conclusion has not been reached regarding out-of-hospital care. This type of coverage cannot be implemented until clearer standards are available regarding the best locus and method for care.

Public Expenditures for Mental Health Care in Massachusetts

Authority and responsibility for the care of the mentally ill in Massachusetts rests with the Department of Mental Health. Its expenditures constitute the greater part of expenditures for care. The Department's budget has grown from $57,209,940 in 1959 to an estimated $82,547,180 in 1965.

In the period 1959-65 operating expenditures for state mental hospitals went from $37,952,115 to $50,-730,753. The budgets of the Department's two other major service programs, both primarily outpatient, have increased in even greater proportion. The Division of Mental Hygiene expended $786,857 in 1959 and will spend approximately $1,717,380 in 1965. The Division of Legal Medicine doubled its budget from $534,557 in 1959 to approximately $1,078,800 in 1965. (Budget increases in both divisions have been paralleled by additional services in the form of adult and child guidance clinics and facilities serving courts and penal institutions.)

More than $62,000,000 has been expended for new buildings and plant renovation since the end of World War II. An additional $24,000,000 has been authorized for this purpose. Slightly more than $4,-000,000 has been authorized for community mental health centers.

Fiscal Responsibility for Care of the Mentally Ill

When a state embarks on a new venture, such as the comprehensive community mental health programs recommended in this report, three basic fiscal questions must be considered:

- How will the money be raised?
- Who is responsible for funding the services?
- How much will it cost?

There are many devices through which funds can be secured. In the private sector, voluntary contributions, fees and government grants-in-aid are the primary sources. Federal funds are raised through general taxes. On the state level money is raised through methods such as general taxation, specially designated taxation, bond issues and grants-in-aid from the federal government. It is likely that the comprehensive mental health programs will utilize funds from all these sources. Choosing the appropriate fund-raising device for a particular service is a complex task.

As this report is written, serious consideration is being given to major adjustments in the Commonwealth's tax base. The eventual decision on the tax questions before the legislature will clearly affect the choice of funding approach for the community mental health programs. This report can do no more than raise the issue. Considerations which go into the final decision are beyond the scope of this Project.

Relative responsibility for funding mental health care is considered in the outline which follows:

Financing Construction

GOVERNMENT RESPONSIBILITY

Provision of the physical plant and facilities for the mentally ill is historically a responsibility of government. The magnitude of the problem makes any other proposal unrealistic. For the following reasons the federal government should assume a major share of this fiscal responsibility:

- The problem is a national one which transcends state boundaries due to the mobility of population. Therefore it must be met on a national scale.
- Unequal distribution of assets and incidence of mental illness between the states com-

bined with the broader tax base available to the federal government makes federal financial participation a matter of equity.

- Participation and assistance by the federal government should stimulate states to assess their problems realistically and to join with the federal government in the financing of facilities.

Short-Term or Non-Custodial Care Facilities

Fiscal responsibility for construction of facilities for outpatient clinic care, day care, night care, inpatient short-term care and similar non-custodial care facilities should be a shared government and voluntary responsibility.

State operated community mental health centers or other facilities should be financed jointly by state funds supplemented by federal matching funds under the Community Mental Health Center Act or other similar federal and state legislation. Insofar as the state's share is concerned, revenue should be derived from the general treasury and not from specially designated taxes.

Municipal hospital psychiatric facilities should be considered no different from those under other auspices so far as maintenance of facilities for the treatment and care of the mentally ill is concerned. Construction and maintenance of facilities should be financed with a combination of federal, state and local tax revenue.

Voluntary, nonprofit agency operated community mental health centers or other noncustodial-care facilities including the general hospital, should be financed jointly by public subscription funds plus federal supplementation under the Community Mental Health Center Act, or other similar act, where appropriate.

Private proprietary psychiatric facilities should finance construction and maintenance of facilities through the investment of those professional individuals or groups who operate them.

Long-Term or Custodial Care Facilities

Construction of these facilities, largely inpatient-care facilities, should be financed by a combination of federal and state dollars on a matching fund basis. This responsibility should apply whether such facilities are constructed separately or in conjunction with a short-term or non-custodial care facility.

Insofar as the state's share is concerned, revenue should be derived from the general treasury and not from specially designated taxes.

Financing the Provision of Services

Short-Term or Non-Custodial Diagnostic and Treatment Services

In Governmental Facilities For those who can afford it and choose treatment in a government facility, it should be rendered on a realistic fee-for-service basis. Third-party private insurance contracts should not exclude payment for care in facilities operated under government auspices.

Care for those who are eligible for inclusion in public assistance under one of the welfare categories should be financed through the federally assisted welfare program.

For those who cannot afford to pay, the state should assume part or, if necessary, the total cost of treatment. These services should be financed and administered through the Department of Mental Health.

Federal funds, on a matching basis, should be available to supplement state funds for staffing and provision of services in government facilities. Funds could include, but not be limited to, demonstration projects.

In Municipal General Hospitals As previously indicated, there is some question regarding the legal right of municipal hospitals to provide certain psychiatric resources. This question should be resolved and municipal hospitals should be permitted to offer the same services as general hospitals operated under private voluntary auspices. Financing devices recommended for general hospitals should apply to municipal hospitals except local tax funds should be used to underwrite service deficits in lieu of voluntary contributions.

In Voluntary, Nonprofit General Hospitals For those who can afford them, services should be paid for on a fee basis in whole or in part.

Services should be covered by insurance and other third-party arrangements when appropriate.

Care for those who are eligible for inclusion in public assistance under one of the welfare categories should be financed through the federally assisted welfare program.

For those who cannot afford to pay in full, and unable to qualify for a federally assisted welfare program, government should assume part or, if necessary, the total cost of the diagnostic and treatment service.

Federal grants-in-aid should be provided for operation of facilities constructed with federal participation under the Community Mental Health Center, Hill-Burton or similar acts.

The state, through the Department of Mental Health, should purchase services to the extent such services are established by public policy as those which should be made available to all persons who need them.

Government participation should include financing demonstration projects.

Costs of service not covered by the above should be met through voluntary contributions.

In Voluntary (Charitable) Agencies For those who can afford them, services should be paid for on a fee basis in whole or in part.

Services should be covered by insurance and other third-party arrangements when appropriate.

Government participation in financing these services should be limited to the purchase of service for those unable to pay and for demonstration projects.

Costs of service not covered by the above should be met through voluntary contributions.

In Private Psychiatric Services Private psychiatric services are not a governmental responsibility. Payment should be made by the recipient of services either directly or through third-party payments. An exception would be the purchase of service by state governmental agencies from private psychiatrists for those unable to pay or when community mental health programs are unavailable or inappropriate.

Long-Term or Custodial Care Services

Responsibility for the care of persons with long-term or chronic illness has been recognized by the federal government in provision of categorical Aid to Persons with Permanent and Total Disability and in Medical Aid for the Aged and by the state of Massachusetts specifically in the field of mental illness with state assumption of responsibility of providing and financing care for all insofar as they cannot afford to pay.

Provision of care and treatment for the long-term mentally ill cannot realistically be separated from the provision of a physical plant and facilities. It includes a major responsibility by the federal government for the same reasons given for federal governmental responsibility for physical facilities. The following recommendations are made concerning methods of financing and do not relate to the actual location where services are provided:

- The federal government should participate with the states, on a matching basis, in the financing of staff and treatment services for the long-term mentally ill.
- The federal government should extend its current program for demonstration and hospital improvement grants within the state system in institutions for the care of the long-term mentally ill.
- Public assistance programs should be modified to include care of institutionalized chronic long-term mental patients under categories of Medical Aid to the Aged and Aid to the Permanently and Totally Disabled.

Fiscal responsibilities suggested above should apply whenever the patient is properly admitted to an approved mental health service.

Financing Preventive and Ameliorative Programs

Programs looking toward prevention cannot be divorced from treatment programs. In mental health, as in public health generally, the preventive function should be shared by the government and voluntary sectors. Financing must therefore come from both voluntary and governmental resources.

There is no clear line of demarcation for the financing of these services. The task of providing effective preventive programs in mental health requires cooperation and coordination of both voluntary and governmental resources. While there are realistic limits to resources, whether governmental or voluntary, clearly the resource potential of the voluntary is more limited. Government financial participation in programs of prevention under voluntary auspices should include purchase of services and demonstration programs.

Preventive programs in mental health could include:

- Individual and family counseling agency services such as voluntary family and children's agencies or family and children's services under public welfare auspices; settlement and other voluntary neighborhood agencies or public recreational and anti-delinquency programs; voluntary group service agencies such as Y's, Jewish Community Centers, C.Y.O.'s, or such special governmental services as those developed under the Economic Opportunity Act and the State's Commonwealth Service Corps.
- Activities of caretaker groups such as clergymen, lawyers, nonpsychiatric physicians, court, police probation and parole personnel, educators and public health nurses.

Financing Research

Responsibility for financing mental health research has been, and should continue to be, shared by governmental and voluntary agencies.

Tax supported mental health research should be financed from both federal and state funds. The state has an obligation to provide research money in order to realize the maximum potential of other research funds. The state and voluntary agencies also have an obligation to support research directed toward evaluating their programs and activities.

Financing Training

Financing of training of personnel for mental health programs is a responsibility which should be shared by government and voluntary agencies.

State Universities and Colleges

Financing of training programs at state universities and colleges is primarily a government responsibility through state taxes, federal grants and scholarship programs. To a lesser extent costs can be met by student tuition.

Private Universities and Colleges

Training at private universities and colleges should be supported by public subscription and student tuition. Federal grants and scholarship programs could supplement the funds.

Although the anti-aid amendment prevents direct subsidy, the state government should assume responsibility for the establishment of scholarship programs and programs of educational leave to state employees for professional study.

Graduate Students in Agency Settings

In many cases financial support must come from a combination of resources available to the educational institution and the service agency in which the student obtains his practical experience.

Inservice Training for All Personnel

These should be financed through the previously identified resources available to the agency. However, in most private and all governmental agencies the federal government has a special responsibility to support inservice training through grants and demonstration projects.

Costs of Community Mental Health Programs

Community mental health services will continue to be offered under many auspices. However, the principal provider of funds will continue to be the state. Even in nonstate programs, the government will be responsible for the treatment of many lower income citizens, on a fee-for-service basis. Therefore, the cost of the programs as they affect the operation of the Department will be considered.

As we move into new types of programs, it is difficult to project costs without a base of operational

experience. Provision of comprehensive community services will require the development of 25 new community mental health programs with or without a center. Added to programs in the existing 12 state hospitals, the 37 proposed areas will be serviced.

Capital Expenditures

Although the program rather than the center concept has been continuously emphasized throughout this report, there will be expenditures for capital outlay. However, it is not believed that construction of community mental health centers will materially alter future capital expenditures already anticipated by the Department of Mental Health. The Department's existing facilities are old. If the existing programs were to continue unchanged, it is obvious that considerable capital outlay would have to be expended for replacement or rehabilitation of deteriorated structures. As a result of the community mental health programs, the inpatient load on state hospitals will be reduced markedly. Obsolete structures can be retired rather than refurbished or replaced. This saving should cover a major portion of the construction costs of the community mental health program. Additionally, state funds will be augmented by federal construction money under the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

Operating Costs

The principal increase of expenditures will arise from operating and administrative costs.

Expenditures for the state hospitals will not be lowered despite their decreased inpatient responsibilities. With smaller populations, it will be possible for the hospitals to redeploy resources to provide more adequate continued care and service and to operate their own community mental health programs. Major new expenditures will be for the operation of 25 new community mental health programs. Based on the budget estimates for one program being developed within the Commonwealth and figures suggested by the National Institute of Mental Health, projections of costs can be determined. A community mental health center which provides a full range of services for adults, children and special services for the retarded to a population of about 175,000 will require a total staff of 175 professionals and nonprofessionals as follows:

Psychiatrists	20
Psychologists	10
Social Workers	27
Registered Nurses, Licensed Practical Nurses and Attendants	40
Rehabilitation Therapists and Educators	21
Stenographic, Clerical etc.	27
Supporting Professional Staff	6
Service and Maintenance Staff	25

Salaries plus ordinary operating expenses will come to approximately 1½ million dollars a year. It is assumed that two or three new programs will be instituted each year starting with Lowell and Fall River in 1966. This would add approximately 3 to 4½ million dollars a year to the operating budget as follows:

Year	*Cumulative Number of New Community Programs**	*Cumulative Budget Increase*
1966	2	3 million
1967	4	6 million
1968	6	9 million
1969	8	12 million
1970	10	15 million
1971	13	19.5 million
1972	16	24 million
1973	19	28.5 million
1974	22	33 million
1975	25	37.5 million

* In addition to the 12 programs centered in state hospitals

An additional 1½ million dollars might be needed for increased central office and regional administration services. At the end of ten years, expenses directly related to community mental health programs will increase the Department of Mental Health's fiscal needs by about 40 million dollars or about $10 annually per resident. Based on the probable increased cost of living and possible improvements in service beyond what is now envisaged, the cost may be higher. At this time it appears almost certain that there will be some federal contribution to operating costs, at least on a time-limited basis.

These estimates of operating costs do not include the special institution for the epileptics, the institutional programs for the retarded and the special allocations for research and training. A special retardation study is now underway and recommendations will be forthcoming by September of 1966. In addition, this report has recommended a continued study to determine the future role of the Department of Mental Health in providing services to epileptics.

This report recommends sweeping new programs. They are not inexpensive. It is our belief that the potential benefits to the citizens of the Commonwealth merit this expenditure.

Can Massachusetts Afford a Community Mental Health Program?

This question eventually must be answered in terms of the program's value to the people of the Commonwealth rather than in terms of dollars and cents. Many fiscal experts agree that our state, with the eighth highest per capita income in the country, can afford any services its citizens really want.

It has been vociferously claimed that any tax increase to provide additional public services would constitute an unconscionable burden on the taxpayers. This view is based upon the myth that Massachusetts residents are the most taxed in the country. In fact, when government income from all sources is compared on a per capita basis, Massachusetts ranks 15th of all the states; among the ten comparable leading industrial states, the Commonwealth is fifth. The figures are even more revealing when government revenue is calculated on the basis of resident's income. *Massachusetts ranks 37th among the 50 states in the portion of each taxpayer's income that is collected by*

state and local government. Only 13 states collect less taxes per $1,000 earned than Massachusetts.

While Massachusetts is far from the most taxed state, the question remains, to what extent are we willing to tax ourselves to provide community mental health services. This is not a question of financing, but of unmet needs.

We believe the question to be answered is "Can Massachusetts afford not to institute a community mental health program?"

LEGISLATION

The responsibilities of the Planning Project did not include the drafting of legislation. However, it seems clear that new legislation amending the Mental Health Laws of the Commonwealth will be necessary to carry into effect the recommendations contained in this report. As an aid to the Department of Mental Health in preparing legislation, the Planning Project organized a committee which will be available to the Commissioner of Mental Health for his consultation after this report has been submitted.

It should be noted that the Planning Project maintained close contact with the Special Commission on Mental Health which was established by the General Court to investigate and to recodify the laws on admission and discharge of mental patients. Because of the intensive examination of the so-called "commitment laws" conducted by this commission, only limited attention was given to this subject by the Planning Project. However, joint meetings were held between the research staffs of the Special Commission and the Planning Project to exchange views and information. The results of this coordination are shown in the report of the Special Commission to the General Court this year wherein the recommendation was made that actual legislation not be submitted by the Special Commission to recodify the commitment laws until after the release of the report of the Planning Project. This was suggested in order to reflect the recommendations of the Planning Project in the legislation and to enable the General Court to consider recodification of the laws in the light of the future plans for mental health care and administration as drawn in the report.

Another aspect of the work of the Planning Project has a particular bearing on legislation. Many suggestions for legislative action were made at a series of public hearings held throughout the Commonwealth during the past year. Those adopted by the Project are contained in this report. Other suggestions for new laws or for changes in existing law which did not come within the responsibility of the Project were communicated to appropriate authorities. The Department of Mental Health and the proposed mental health advisory council should continue with these public hearings as a regular, periodic practice as one of the means of increasing citizen participation and involvement in the mental health programs of the state.

These hearings can provide a very important service to the Department by keeping it aware of needed changes in the mental health laws of Massachusetts.

ADULT MENTALLY ILL

The World We Live In

Adult mental illness has the dubious distinction of mirroring the complexities of a society which is thought to bear down more heavily on individual man than did society in other ages. Anxiety, alienation, apathy, and an anarchic repudiation of once precious values are but a few of the negative features currently in vogue. Reasons abound for explaining these aspects of man's social behavior. In addition to biological and psychological explanations, they include the threat of atomic holocaust, the effects of revolutionary advances in science and technology and the effects of our obsessive tendency to rely upon impersonal, bureaucratic, corporate mechanisms. Underlying these different interpretations is a widely felt fear that the rapid pace of social change is running too far ahead of the adaptive capacities of individual man and his social structures. Traditions, institutions, and mores which help members of a particular society to exist stably within a definite framework of predictable social relations are being impugned or dislocated. Therefore, certain consequences may inevitably follow including mental illness.

Many questions were considered by study groups for which there were no satisfactory answers. For example, "Was a narrow or sweeping delineation of mental illness best in the long run?" "How much of the total supply of scarce mental health resources should be funneled into certain preventive and treatment activities when available evidence questions their deterring and restoring effects?"

Deliberations aimed at perceiving the major issues of planning in the years ahead. These issues related mainly to the changing character of services, the changing role of various health facilities (including mental hospitals, private hospitals, general hospitals, clinics, and the proposed mental health centers), the changing character of professional functioning, and the changing relationships between mental health programs and local communities. Disagreements were mainly concerned with the details of the best method to use to achieve generally agreed upon goals and policies. More fundamental philosophical, theoretical, and jurisdictional disagreements, which did exist, were set aside in the interest of completing the practical task of analysis of the problems.

Research Stressed

Above and beyond anything else, reports stressed the urgency for research into the basic unknown areas of mental disease. Emphasized throughout the investigation was the need for research to evaluate ongoing programs espoused with enthusiasm based more on faith than actual outcome. Since the problems of mental illness cannot await the closing of

huge gaps in existing knowledge, this report takes a pragmatic view in its proposals for handling the problems of the adult mentally ill in the immediate future.

Early Recognition

Experience has shown that, at least in some instances, the earlier a patient is treated the better his chances of recovery. Surely, the earlier the illness is recognized, the better the chance of keeping the suffering to the patient and to those with whom he is involved at a minimum. In addition, the better the chance of avoiding the kind of chronicity that seems to come with neglect.

If early recognition is to be attained and appropriate help is to be given, there must be changes. Better education of lay and professional persons, more realistic solutions to manpower problems, more emergency and other facilities and better and more efficient screening procedures are only a few requirements. Local planning efforts need to do everything possible to reduce territorialism, safely-guarded narrow agency interests and competition and distrust between agencies. All these factors create unfortunate wastage and obstruct paths toward needed services.

Proper Treatment

Fortunately, effective treatment is possible in spite of the lack of knowledge as to cause. In the treatments available today, variety is conspicuous. It is no longer logical to grant any single discipline a monopoly in treatment. Revolutionary discoveries that will solve all our problems should not be sought from any single professional group. Significant insights into specific forces behind adaptive as well as maladaptive behavior will no doubt be made by future specialists. The idea that man is a multi-influenced creature is well established. Responsibility for the mentally ill, for socially controlling various deviants, and for finding practical and humane solutions to large and small human problems has to be a collaborative venture.

Increased efficacy in achieving the goals of treatment and rehabilitation in recent years can perhaps be linked directly to concepts of community care. While community concepts have been strongly influenced by social theories, in practice they represent an historically important merger of psychological and sociocultural constructs.

Ideal Community Care

Future programming should place particular emphasis upon bringing the ideals of community care within realistic range and might include the following:

- As a means of detecting problems as early as possible, a sufficient number of community clinics, mental health centers and psychiatric units could be established in general hospitals. When possible, treatment should recognize the needs, culture and ethos of the local patients.
- Basic administrative and therapeutic goals of mental hospitals might concentrate on short-stay rather than long-stay treatment. However, the salutory effects of temporary isolation or the profound value of intensive psychotherapy in appropriate cases should not be overlooked.
- As alternatives to custodial care, long-stay patients might be introduced to the ideals of democratic self-government and exposed to increased social opportunities as part of therapeutic programs.
- Increased experimentation with new patterns of care and different forms of organization can only aid progress. Emergency services, day hospitals, night hospitals, foster family care, ex-patient clubs, halfway houses and aftercare clinics are only a few that could be made available.

Basic to all these programs is the idea that the mentally ill are served best when all restorative efforts remain part of and functionally integrated within communities, not isolated from their mainstreams.

Recommendations

In examining in some detail the status and needs of the adult mentally ill in the Commonwealth, attention has been focused on ideal goals as well as practical possibilities. A consensus is reflected in the following recommendations. If carried out, the recommendations will result in substantial and continued improvement in the lot of the adult mentally ill in Massachusetts.

Recommendations appear under headings which signify specific areas of need.

Public Mental Hospitals

71. State hospitals should be developed along the lines of the community mental health center, contributing a multi-faceted treatment program to the regions they serve.

Working collaboratively with important segments of the community's care-giving system, local citizen groups should be given a voice in program planning and development.

72. Each state hospital should be conceived and developed as an integral component of the community's total program and should participate directly in planning and developing that program.

Staffing problems and isolation should be reduced through increased utilization of contract services and the establishment of closer functional ties with universities and with the Department of Mental Health.

73. State hospital programs should be broadened to include emergency care, alternatives to hospital care, rehabilitation services, aftercare, consultation and mental health education as well as in-hospital care.

74. Adequate aftercare services for rapidly increasing numbers of released patients should be given very high priority in the years just ahead.

75. Commitment laws and procedures should be revised with the dual aim of directing patients to appropriate treatment facilities and easing the movement of patients through various treatment facilities.

Commitment papers should explain an individual's option to enter the hospital voluntarily or to seek emergency help first.

Private Mental Hospitals and General Hospitals

76. All general hospitals in the Commonwealth should accept psychiatric patients on the general medical wards or in a special psychiatric ward.

Psychotherapy and the somatic therapies, such as electric shock and psychiatric drugs, should be available. Emergency service should be given around the clock.

77. Local general hospitals should be given high priority as possible sites for the establishment of community mental health centers.

Many people think that it is easier to come to a medical facility to be treated for any illness than it is it to come to a separate structure designated as one where mental illness is treated. The hospital of the future will not only be a place for the treatment of the sick, but also a community health center, with mental health programs being one of its services.

78. Certain existing private mental hospitals should be considered as appropriate nuclei for community mental health centers where local circumstances make such a development feasible.

79. Opportunities should be expanded for training non-psychiatric physicians in the handling of less serious psychiatric problems in their own practices.

Special training would enable physicians to continue treatment of more serious problems in general hospitals, in private psychiatric hospitals' open staffs or even in public mental hospitals through contract arrangements with the Department of Mental Health.

80. Private mental hospitals should be integrated into the total effort of the Commonwealth to provide psychiatric services to all its citizens.

The Department of Mental Health should take the lead in fostering better working relationships between private hospitals on the one hand and the Department of Mental Health, public mental hospitals, and local social agencies on the other.

81. The Department of Mental Health should be permitted to contract with private organizations and individuals for services to individual patients.

Outpatient Clinics

82. An immediate objective should be the availability of one outpatient clinic for each of the community mental health areas to be established in the state.

At least one clinic for each 50,000 population would be the long-range goal.

83. Every outpatient clinic should have access to emergency care services for persons in need of immediate help.

Greater flexibility and imagination should be employed in the use of personnel to meet psychiatric emergencies. Staff should be willing to leave their offices under appropriate circumstances. A corps of persons (social workers, physicians, nurses, clergy, retired professional workers, and specially trained counselors) should be developed for use in emergencies.

84. Clinics should make greater efforts to extend treatment services to difficult conditions often overlooked (alcoholism, psychopathy, sexual perversions) and most frequently in need of attention.

85. Clinics should recognize the differences between purely managerial-executive functions, administrative functions and clinical functions.

Promising clinicians should be permitted to rise professionally, receiving suitable economic compensation, without having to move into administrative positions for which they were not trained.

86. Evening clinics and more evening hours should be provided for those who cannot interrupt their work during the day for needed treatment services.

Supporting Services by Other Than Mental Health Personnel

87. Nonpsychiatric physicians should be trained and encouraged to provide psychiatric care for the emotional, behavioral psychosomatic and less serious psychiatric problems in their practices.

88. Under certain conditions (training, adequate supervision, consultation) selected individuals may be followed in a counseling relationship by clergy, teachers, probation officers and other lay individuals.

89. New and imaginative ways should be developed for expanding the role of volunteers in mental health programs.

90. Activities of existing agencies in the total social-welfare complex in case finding, screening, referral and treatment should be related to the proposed community mental health programs and other planning bodies.

Courts, nursing services, public welfare departments, voluntary family service agencies, community settlement houses, community welfare councils, mental health associations, school systems, labor and business organizations and professional societies should work together to achieve the maximum benefits of a fully integrated community mental health program.

ADULT CRIME AND JUVENILE DELINQUENCY

Newspaper headlines daily print stories about the increase in crime and delinquency. These are key issues from town meetings to national elections. Beyond the heat of headlines and the polemics of politics, mental health practitioners and allied professionals recognize the grossly deviant behavior raising problems for many systems including the correctional, judicial, political, religious and educational. A great part of the responsibility for prevention and rehabilitation is traditionally accepted by the mental health community.

Available Services

Massachusetts has a vast network of social and psychiatrically oriented agencies involved with the problem of crime and juvenile delinquency. They include child guidance centers, outpatient adult clinics, family and children's agencies, community centers, Y's, boys' and girls' clubs and many programs sponsored by religious organizations. Services include psychiatric, psychological and casework treatment; group therapy and social group work; recreational and street work and pastoral and secular counseling. Psychiatrists, psychologists, social workers, physicians, nurses, clergymen and a host of caregivers are involved in these programs.

An extensive network of programs are offered for the juvenile offender. More than 1,600 juveniles are seen annually in the 12 court clinics, where they are diagnosed and/or treated by professionals from the Division of Legal Medicine. Services to about 2,700 inmates in Massachusetts Correctional Institutions are provided by psychologists, psychiatrists and social workers by the Department of Correction and the Division of Legal Medicine. In addition, approximately 700 patients in the State Hospital for the Criminally Insane at Bridgewater are also served. The Division of Youth Service, with the help of the Division of Legal Medicine, is responsible for providing treatment and diagnostic services to more than 3,000 young offenders.

Clearly, Massachusetts has many mental health services for the juvenile delinquent and the adult offender; perhaps more than in most states. However, much remains to be done to extend services and integrate goals.

Services Lacking

Some graphic examples of deficiencies are:

- Although more than one-third of the state's population lives in districts served by court clinics, most District Courts and all but one Superior Court, have no court clinic or other mental health service available except in the state hospital.
- Less than 45 full-time professionals in the Division of Youth Service provide service for the total caseload. As a result, field treatment facilities are inadequate although diagnostic services are somewhat better.
- The 200-250 residents of the three county training schools receive no professional diagnosis or treatment. Mental health services within state correctional institutions are offered on a limited basis to the general inmate population.
- Demand for service far exceeds what is available.
- There is no adequate effort directed toward working with predelinquents in the community in terms of either service or consultation.
- Trained and untrained street workers who are closely related to neighborhood youth are not used often enough. They could serve as a connecting link between these alienated youth and community agencies.
- In recent years mental health consultation to Bridgewater State Hospital has improved. Nevertheless, as a mental health enterprise it has deficiencies that seriously limit an effective approach to modern mental health practices.
- For all practical purposes there is little or no impact made by mental health services in the houses of correction.
- Because the correctional process is so administratively fragmented, the need for integrated mental health services is imperative. Particular caution must be exercised in relating court and correctional activities to community mental health programs to assure the provision of services without further fragmentation.
- Although the Department of Mental Health has the potential of coordinating mental health services to the correctional field, the Department has neither the personnel nor the administrative cohesiveness to do the job.
- Because of the nature of the correctional patient and the incomplete orientation of correctional personnel toward mental health principles, the increased demand for the provision of mental health services must depend on a practical demonstration of service.

RECOMMENDATIONS

It seems clear that there must be a substantial increase in the allocation of both financial and professional personnel resources, if services in this sector are to meet the demonstrated need. Equally clear is the requirement that existing resources should be coordinated in a more effective manner. The programs of several state-level departments, local and county governments, as well as voluntary agencies are involved. This, of course, complicates the task of coordination. The community mental health programs, at both the local and regional levels, through consultation and direct services, could serve as a keystone for such an effort.

Meeting the total need is a vast problem, much of it beyond the scope of this Project. Within these limitations the following specific recommendations are made as initial steps to alleviate the situation.

91. Court clinic programs should be extended to all district and superior courts in the Commonwealth. Beyond the urban centers court clinics may well have to expand their intake policies to provide continued care for released offenders.

Often this will be accomplished best by courts sharing clinic personnel.

92. Increased attention should be given to the provision of aftercare services.

This calls for a thorough review of the parole system as it relates to institutional treatment programs.

93. Priority for admission to prevention and treatment programs should be given young people, particularly in socially and economically deprived areas.

94. Minimum academic standards should be set for mental health staff members of the Division of Youth Service. Additional staff should be added providing a ratio of one mental health staff member per 25 children.

95. Inservice training programs should be conducted by mental health specialists to teach correctional personnel to see themselves as effective rehabilitation agents.

These programs would help to realize the potential of adult correctional institutions as effective instruments of rehabilitation.

96. Consideration should be given to instituting treatment and rehabilitation programs in the houses of correction.

97. A research and information center is needed to provide the knowledge and current information upon which effective agency operations must be based.

98. An adequately staffed and financed interdisciplinary committee should be appointed by the Governor to thoroughly evaluate and make recommendations concerning the state hospital at Bridgewater and future programs for the criminally insane.

The future of the State Hospital at Bridgewater must be clarified. Consideration must be given to the adequacy of its plant, its function as a state hospital, and to the administrative structure under which it is to be operated. Indeed, consideration should be given to the wisdom of maintaining an institution specifically for the criminally insane.

AGING

The Problem of the Aged

Not everyone over 65 needs mental health care. However, the aged are more likely to require hospitalization; to suffer from loneliness; to have fatal accidents; to be poor or undernourished or both; and to choose suicide as a solution to their problems. These mishaps are a reflection of the great stresses placed upon the elderly. The higher incidence of state hospital admissions among those over 65 is a direct reflection of their mental health needs.

Data regarding the over-all needs of older people are not available to the extent they are for other groups. Even less is known about their mental health needs. Absence of reliable studies makes an accurate estimate impossible. Existing data indicate that five percent of the aged are in institutions and that an additional 10% are social isolates. Mental health services, in the broadest sense, may be needed by more than one elderly person in seven. This represents about 75,000 people in Massachusetts. Included in this group are 25,000 known to reside in nursing homes and rest homes and another 6,500 in institutions of the Department of Mental Health. The balance, about 40,000 people, reside in the community with only limited resources available to them.

Increasingly, community agencies have acknowledged the needs of the aged. Although they have started to provide specialized services, they have been unable to keep pace with the rapid growth of the geriatric population. As the comprehensive community mental health programs develop, even greater numbers of older people with mental health needs are likely to be discovered. This will require increased availability of many services under both public and private auspices. Community mental health programs can be important resources, but only as an integral part of a community complex of services such as social agencies, adequately staffed public welfare departments, protective departments, general hospitals, and nursing and rest homes. The particular passivity found among many persons of advanced age requires active casefinding techniques on the part of these agencies and the community caretakers groups, including doctors, lawyers, nurses, clergymen and law enforcement officials.

With so many agencies involved, it is only reasonable to expect that there may be wide differences in suggested approaches to the problem of providing mental health services for the aged. Typical dilemmas can be summed up in a series of questions:

- Should we concentrate on prevention or treatment?
- Should treatment be organic or psycho-social?
- Should the aged receive special treatment or would this be artificial segregation and discrimination?
- Should the aged be returned to participate as fully as possible within the community structure?
- Should services for the aged be specialized or allow for more diversification?
- Should funds be expended upon research when services are so vitally needed?

When considering the problem of the aged several factors must be noted. An adequate program will be costly; voluntary and private services and facilities must be encouraged as well as public services and facilities; and personnel should be increased and utilized more effectively. In any event action is sorely needed.

What is the Role of the Department of Mental Health?

Designating which agency of the Commonwealth should take the initiative in developing protective services for the elderly is a matter open for debate. The fact that a core problem of aging has to do with mental functioning, mental competence and personal rights places it in the general area of clinical psychiatry on the one hand and forensic psychiatry on the other. These considerations, in addition to the fact that the Department of Mental Health is a social agency of the Commonwealth as well as a medical one, suggest that the initiative for developing protective services for the elderly should be a responsibility of that Department. The historical fact that psychiatric social work and social psychiatry were pioneered in America by psychiatrists and social workers of the Massachusetts Department of Mental Health indicates that the latter has assumed responsibilities in related areas in the past.

RECOMMENDATIONS

99. Regional inpatient geriatric centers are needed.

Logistical planning requires that certain facts about the Department of Mental Health and the population of Massachusetts be considered. The Department of Mental Health is undergoing a rather rapid transition in its mode of operation. There is increasing expansion among the older-age group in Massachusetts and in the nation. These facts must somehow be brought into the same field of planning.

The 12 mental hospitals of the Department are undergoing a rather rapid decrease in population largely due to successful treatment and discharge of the younger patients. If all these hospitals follow the course of Worcester State Hospital, a new situation will exist within a few years. This situation will be characterized by a custodial population consisting of a high proportion of geriatric patients and a large number of unoccupied beds. Since the developing community mental health centers would be expected to care for younger patients, the pressures on the existing state mental hospitals would be decreased for this.

On the basis of these trends, it seems reasonable to forecast that in a few years the Department of Mental Health will have 12 hospital facilities with far fewer patients in far fewer beds. Many, or perhaps most, of these patients will be in the geriatric age range. Whether or not the remaining bed space of some of these hospitals should be utilized to provide protected settings for geriatric patients will be the question. This will be especially pertinent when there are no accommodations or health and social services in the communities for those who need the range of services that a hospital can provide.

100. A major inpatient geriatric center along the lines of Cushing Hospital should be established with a state hospital in each of the six mental health regions.

Each center should provide living accommodations and services especially tailored to the needs of the geriatric patient. Since the social disability of the infirm elderly is frequently due to impaired mental functioning and emotional disturbance, it seems reasonable to assign a large measure of responsibility for their care to the Department of Mental Health. It should be emphasized that this assignment of responsibility is viewed as a temporary holding operation due to the absence of adequate resources and facilities in the local communities of the Commonwealth. Indeed, an important role of state hospital geriatric service centers would be to actively assist local communities to develop community-based facilities.

101. More must be learned about the incidence and nature of incapacities of the aged resulting from mental impairment.

Lack of available data concerning the extent of this problem among the aged partially reflects a relative disinterest in such research among workers in the fields of medicine and social science in Massachusetts. It is also a reflection of the nature of the problem. The aged lack visibility and remain in the shadows. This tendency relates directly to a need for active casefinding in the community. Casefinding must be coupled with extensive research if the full extent of the problem is ever to be revealed.

Reasons for the lack of research into social and situational causative factors can be explained, in part, by an a priori assumption that nothing can be done for the aged. This is a perception that tends to be shared by the aged themselves and by many of the professionals involved. Responsible social planning and investigations should be free of such assumptions.

102. Comprehensive community mental health programs must have services tailored to the needs of the aged residing in the community.

All too often community resources offer little more than token service to the elderly. In the competition for services, the elderly frequently lose out to other groups served by the community agencies. A comprehensive community mental health concept requires open intake and service for all without discrimination as to diagnosis or age. Despite the limitations on resources which all agencies suffer, the community mental health programs must include emphasis on the needs of the elderly.

103. The Massachusetts Commission on Aging should assume more of a role in the coordination of services and in the representation of the problem of the aged before the public.

With the expansion of their role, the Commission on Aging could represent the aged in the legislative processes and could aggressively support the need for research.

ALCOHOLISM

The Tremendous Scope

Many mental health practitioners believe that alcoholism is the most pressing issue facing them today. Based upon 1960 estimates, approximately 200,000 alcoholics live in the Commonwealth of Massachusetts. During the last five years, alcohol disorders have accounted for approximately 25% of all male admissions to state mental hospitals. At the Boston City Hospital, clinicians estimate that of 45,000 annual inpatient admissions each year, 15,000 are either directly caused by or closely related to the problem of alcoholism. Alcoholism's overwhelming impact on the community is perhaps most dramatically shown in data available from the Boston Police Department. More than 21,000 arrests for drunkenness were made during 1963 and more than 3,000 of this group were committed to correctional institutions. Court data suggests that alcohol problems are present in more than half the cases involving child care and custody. In cases of juvenile delinquency, it has been estimated that 50-60% of the defendants have one or both parents who suffer from alcoholism.

There is a popular stereotype which casts the alcoholic in the skid row image. However, it is likely that this group represents no more than 10-15% of the alcoholic population. The problem afflicts all social and economic levels. It is generally accepted that about three percent of the work force are alcoholics, averaging 20 days of alcohol-enforced absence from work each year. Nationally the annual cost to business and industry exceeds $1,000,000,000.

Relations to Mental Health

Why is such a broad-based problem of specific interest to the field of mental health? A chronic disorder manifested by excessive drinking, alcoholism, is, among other things, a behavioral problem. Since mental health specialists are trained to deal with behavioral problems, they have a key role in the treatment of alcoholism. Nor is their role limited to treatment. The mental health community also fills a function of primary prevention. Some emotional problems have been noted in all American alcoholics seen at research settings, and the degree to which emotional disorders can be reduced or prevented should be reflected in a reduction in alcoholism rates.

Who Currently Meets the Need?

It would be reasonable to state that virtually all community resources are at some point taxed by the problem of alcoholism. (A recent Massachusetts directory of agencies serving alcoholics and their families listed approximately 150 resources.) Eleven statewide departments or boards are directly concerned with the alcoholic. In addition to the Departments of Mental Health and Public Health, these include the Department of Correction, Parole Board, Probation Department, Department of Public Safety, Department of Public Welfare, Registry of Motor Vehicles, Massachusetts Rehabilitation Commission, Youth Service Board and the Department of Education. A broad range of local voluntary agencies, such as family service, the courts and general hospital are involved as are such caregivers as the clergy, general medical practitioners and the police. Yet, there is surprisingly little coordination and collaboration between agencies. This is not because of a lack of awareness of the problem by various organizations and their directors, but rather because of the complex nature of alcoholism in the community and the varied perceptions of the nature of the alcohol problem. Perhaps, related to this is an unfortunate tendency by various agencies, professional and nonprofessional, to compartmentalize and isolate the degree of responsibility they accept in the treatment of alcoholic patients.

Where do the Present Resources Fall Short?

A list of current service gaps include the following:

- There is a shortage of emergency ward service and treatment facilities for the acutely ill alcoholic. Many institutions and hospitals are reluctant to accept such patients.
- Available medical insurance coverage is too limited to meet the existing needs.
- There are too few adequate rehabilitative facilities such as halfway houses. Homemaker and visiting nurse services are also badly needed.
- While information and referral services on alcoholism problems are available to lay and professional individuals through the voluntary alcoholism committees and the State Division of Alcoholism, these services are not available on a 24-hour basis.
- There is no central registry and data analysis unit to receive and analyze vital statistics dealing with alcoholism.
- Existing alcoholism outpatient clinics sponsored by the Commonwealth of Massachusetts are badly understaffed.

- Even though alcoholics make up a substantial percentage of admissions to our state hospitals, none of these institutions is equipped to deal with the problem. Every effort to secure special assistance has been rebuffed. State hospitals are the major single resource in the state for the treatment of acute alcoholism. Hospitals should be assigned the necessary personnel to take advantage of the patient's therapeutic potential during the crisis of hospitalization.
- At virtually every level of endeavor there is a great need for observation, evaluation and assessment of activities.

RECOMMENDATIONS

Because of the enormous extent of the alcohol problem, many of these recommendations are comparatively modest, but they constitute an enthusiastic commitment toward a humane and scientific goal of helping the alcoholic. The order of these recommendations reflects a priority which recognizes that the availability of funds and personnel are limited and is intended to lay the foundation for future programs.

In addition, the recommendations, even though modest, would involve appropriation of a considerable amount of money as well as the recruitment and training of additional personnel. However, this investment, would eventually repay itself many times over in relieving the tremendous amount of human suffering and economic loss which occurs in the Commonwealth because of alcoholism.

104. More funds should be allocated for investigative programs within state agencies dealing with alcoholism as well as private professional and nonprofessional organizations which deal with alcohol related problems.

Many excellent programs covering various phases of alcoholism and alcohol related problems are now in progress. The directors of these programs and their staffs are so heavily burdened by service responsibilities, it is often difficult for them to evaluate their treatment programs.

It should be made clear that such funds should not come from existing resources which support purely clinical, educational, or caretaking facilities. Diversion of funds from these areas would weaken service facilities at a time when they deserve and require more financial support than they are now receiving.

105. Programs in the mental health centers should be coordinated and planned in relation to other alcohol facilities and resources available in communities.

Depending on location, some community mental health centers may have to supply a complete range of services to the alcoholic including inpatient, outpatient and aftercare services. Other mental health centers should complement the services already available in their communities. In any case, alcoholics will seek the services of the mental health centers. Therefore, staff personnel should be knowledgeable in diagnosing alcoholism, should be aware of available treatment facilities and should deal with alcoholism problems with an appropriate therapeutic attitude. One or more staff people should be assigned this specific responsibility.

Since some general hospitals, and hopefully more in the future, are evolving as health centers within their own communities, similar support and encouragement should be given to these institutions as is provided for state-supported community mental health centers.

In order to bring about effective community mental health programming, alcoholism specialist positions should be established in the Department of Mental Health central office and perhaps in regional offices as well. Their functions should be program development, coordination (both within and outside the Department of Mental Health) recruitment and training.

106. Intensive efforts should be made to modify a number of existing inequities in health insurance programs which discriminate against alcohol related illness.

Specifically, Blue Cross and private health insurance coverage for alcohol related illness should be extended in both amount and duration of benefits. A commission composed of state, medical, and lay officials should be organized and begin to work on this problem in the near future.

107. A central registry and data analysis unit, which would receive final statistics from the many departments dealing with alcoholics, should be established in the Division of Alcoholism, Department of Public Health.

108. A service is needed to provide 24-hour coverage for giving information on alcoholism problems.

This resource could also keep a daily master plan of the available bed space for alcoholics for all hospitals. Since a resource open 24-hours a day would be required, a hospital setting is the most likely possibility.

109. Every effort should be made to increase the coordination of various state and private agencies dealing with alcohol related problems. The Department of Public Health's Division of Alcoholism, which has been assigned this responsibility by statute, should be given the necessary staff to do the job properly.

Services are available to the alcoholic in many different facilities. Unfortunately, treatment of a patient may suffer because of communication gaps between agencies.

110. Additional funds for supporting the various treatment facilities should be sought.

Every resource currently providing services to the alcoholic is heavily burdened with a great demand for service. Because of personnel shortages, they cannot meet this demand. Alternative program efforts for treating the alcoholic should be developed in different parts of the state and in different resources which would include an evaluation of the effectiveness of these services.

111. Halfway house programs should be established to meet the needs of alcoholics returning from correctional institutions, state hospitals and chronic disease hospitals.

COMMUNICATION AND HEALTH EDUCATION

What is the Message?

Amid the helter—skelter of mental health messages emanating from hundreds of lay and professional groups is a public or publics confused and perhaps a bit frightened. Some have concentrated on a positive mental health approach while others have emphasized the mental illness attack. No resolution appears to be within easy reach of professional persons in the fields of communications and health education. This determination of a message and setting of a goal is an absolute must if the public is to receive any directed change in information leading to possible change in attitude or behavior.

There can be no doubt that the language of a mental health message must be chosen carefully. Professionals have sometimes used jargon or have assumed condescending attitudes. Disagreements within the profession have sometimes led to conflicting messages, thereby interfering with their success in reaching the lay public. Yet, there is a body of knowledge in the field of health education which is just as available to the mental health professional as to the communications expert. Methods and materials are known which contribute to aspects of communication relating to the dissemination of information and to the production of attitude and behavior change. Further research by and active coordination between persons engaged in mental health education and mental health professionals would seem to offer the greatest hope of increasing the effectiveness of mental health education.

Attitudes are not Static

Some reports encourage the belief that communications have a key role in keeping the public informed and in securing support or sanction for mental health programs. In addition, communications plays a role in modifying the behavior of the emotionally disturbed, his relatives or his community in relation to identifying, coping with, or getting help for such disturbances. Halpert in *Public Opinions and Attitudes About Mental Health,* summarized nine surveys and concluded that, although these opinions and attitudes vary widely, they are "far from static." In Illinois, public information about mental illness was found to be neither highly structured nor highly crystalized. The survey found that patterns of opinions were not logically grouped. Persons were unsure of opinions and willing to change them fairly readily and they looked to experts for assurance. It concluded that "the public is uninformed rather than misinformed about mental illness."

Some Areas of Agreement

Despite the wide range of opinion concerning communication of information in this field, information experts generally tend to agree on the following:

- Regardless of the specific content to be communicated, communication relating to mental health should span the entire continuum, from matters relating to stress that reduces the effectiveness of healthy people at one extreme, to psychosis at the other.
- Communication relating to mental health should be fostered all along a second continuum, from technical communication among professional people at one extreme, to messages via the mass media addressed to the general public at the other.

The relative degree of emphasis to be assigned to the communication of subjects lying at various points along these continuums and the relative priorities is a matter for continuing study by those in a position to assess the needs of the population of the Commonwealth.

What Then is the Problem?

There are literally hundreds of professional or lay groups releasing statements relating to mental health without benefit of adequate coordination. There is, at present, no adequate centralized source of information, materials, or services for up-to-date, optimal, and statewide mental health communications.

Some groups do not know what others with identical interests are doing. Some valuable information is not communicated outside of the organization in which it originates. Some valuable information is presented so inadequately that even if it comes to the attention of appropriate audience members, it fails to communicate.

The managers of newspapers, radio and television within the Commonwealth are prepared to offer increased cooperation in informing the public on matters relating to mental health. Both professional and volunteer mental health groups seek such cooperation, but agreement on definitions and goals is necessary in order to achieve the required coordination.

Any Hope for the Future?

Projecting the communications picture into the future only tends to magnify the current problems unless steps are taken to alleviate some bottlenecks. Without efforts in this direction, problems will continue to splinter in amoeba-like fashion producing bigger and more complex problems. Newer sources of spreading information faster and wider than ever, combined with more leisure time for most people will only serve to foster the discontent and perhaps even lead to the consolidation of public attitudes contrary to the best interests of the mental health movement. With the construction of community mental health centers in urban areas, communication and education problems will also move into the highly individualistic field of small group communication and education. How to work within ethnic, social or economic neighborhoods will be a real issue and a demanding one. Centers may function or not depending upon the efforts made by communicators and educators in explaining the mental health viewpoint.

RECOMMENDATIONS

The theme running through all these recommendations is one that calls upon mental health professionals to realize that they can no longer shut themselves off somewhere in the country and avoid contact with the public. The people read, listen and watch and know to an ever increasing amount the facts about mental health programs. What they will learn in the future should be reliable and accurate.

Skill and knowledge in fields of mental health communication and health education should be recognized as vital to the efficiency and success of a mental health program.

112. A unit responsible for public information should be established immediately within the Department of Mental Health to coordinate and communicate information on mental illness and mental health.

113. Coordination with federal, voluntary, professional, national, state and local agencies should be undertaken by the public information unit when it is established.

114. Centralized and regional activities should be undertaken by the public information unit with appropriate staff for regional and central offices.

115. A mental health communications council should be established in the Department of Mental Health.

This council would act as a forum and clearing house for those doing mental health communications and education.

116. Priorities should be set regarding communication and information programs based upon an investigation of the needs of the public.

To aid in this effort, communication specialists should be included in bodies responsible for mental health planning, clinical service, administration, teaching and research.

117. Communications research should be encouraged within all programs.

New communication techniques and programs must be developed and tested to evaluate the effectiveness of the messages.

118. Films, pamphlets and other mental health materials must be collected, reviewed and made available in libraries and in central collections.

DRUG ADDICTION

Is There a Problem?

Perhaps no other area of study considered by the Project is subject to as much emotional response on the part of both the lay and professional public as is the use of narcotic and harmful drugs. Because of these emotional overtones and the lack of reliable incidence data, it is difficult to assess the actual extent of the problem. There is even a widespread lack of understanding of the term addiction itself.

Actually there are three major categories of addiction: alcoholism, narcotic addiction and harmful drug use. This section is concerned with the latter two categories. A separate section of the report considers the problems of alcohol addiction. Drugs ordinarily included under the narcotic classification include primarily opium, morphine, heroin, demarol and cocaine. Harmful drugs include barbiturates, chloral hydrate, paraldehyde and some of the tranquilizers.

Surveys have been made to determine the number of drug addicts in Massachusetts. The exact number is not known and estimates range from 500 to 5,000 narcotics users in the Commonwealth. An estimate of the illegal use of harmful drugs is even more difficult to ascertain and has not yet been attempted. It seems clear that narcotic addicts are concentrated within a few areas of the state. Almost two-thirds of the 430 narcotic law violation arrests were in the Greater Boston area. Another 13% were in the resort area of Cape Cod.

In terms of actual numbers of identified users it may be argued that drug addiction does not constitute a major problem within the state. However, there are other criteria and these should not be overlooked in evaluating the problem. Actually very little is known about the true number of narcotic and harmful drug users. Those who work closely with the problem believe that the identified victims represent only a fraction of the total addict population.

Clearly, the use of easily obtained harmful drugs is on the increase, particularly among young people. While there is valid disagreement as to causality, there is an unquestioned connection between drug use and criminal activity, e.g. crimes against property to obtain sufficient funds to support the habit. Among women addicts the criminal activity often takes the form of prostitution.

To an even greater extent than with alcoholism there is a bias, both lay and professional, which inhibits working with the addict. Even when this bias can be overcome, there is very little knowledge or experience available in regard to the etiology and the treatment of drug addiction.

In view of this broad range of considerations—suspected high and increasing incidence, subsidiary cost to society through related criminal activity, lack of fundamental knowledge regarding cause and cure—it seems appropriate to characterize narcotic drug addiction and harmful drug use as a major problem within this Commonwealth.

To the extent that drug addiction is rooted in emotional disturbance and to the extent that intervention is attempted through such mental health techniques as psychotherapy, casework, group work, chemotherapy and rehabilitation counseling, it must

be considered a mental health problem. It is a shared problem which also involves public health personnel, physicians, sociologists, police courts and correctional people. Special emphasis should be placed on this shared aspect. All too often those professionals and caretakers involved in addiction are stereotyped as either punitive or treatment oriented. This stereotyped dichotomy is far from accurate. Among those who served on the Project's task force on drug addiction (and they varied widely in discipline and approach) there was considerable flexibility and an obvious desire to share experiences, to communicate and to learn from the experience of others.

What Is Being Done Now?

Relatively few treatment facilities are readily available to the addict. The major non-public inpatient resources available are private psychiatric hospitals and these are usually quite expensive. General hospitals are reluctant to admit addicts. An exception is sometimes made for middle-class patients, but often under another diagnosis. Physicians, including psychiatrists, avoid accepting addicts as patients. Often, the doctor fears becoming involved in the legal aspects of drug addiction and is, at best, unsure of how to treat the addict.

Government services which are willing to accept inpatient addicts without reservation include the United States Drug Program at Lexington, a program operated through the Boston State Hospital by the Peter Bent Brigham Hospital and a program for those voluntarily admitted to the Massachusetts Correctional Institution at Bridgewater. Addicts are also treated on an inpatient basis by the Salvation Army and at the Massachusetts Correctional Institution at Framingham, if they are voluntary admissions.

It is difficult to ascertain what is done for addicts at the state mental hospitals. As near as can be determined, patients are not accepted with a primary diagnosis of addiction and no special programs for them are in operation (except the new interdepartmental rehabilitation program described below).

On an outpatient basis, the principal non-private resources are the alcoholism clinics operated by the Department of Public Health, particularly the one located at the Peter Bent Brigham Hospital, and the programs of the Division of Legal Medicine and Narcotics Anonymous. Private outpatient psychiatric clinics usually do not treat addicts.

Except as part of the services mentioned above, no special programs are conducted in either the county or state correctional institutions. The Narcotics Anonymous program is making extensive headway in several of these institutions.

Simultaneously with the start of this Project, the legislature created a Drug Addiction Rehabilitation Board composed of the Commissioners of Public Health, Mental Health, and Correction. Under this Board there has been established a Drug Addiction Rehabilitation Center at Boston State Hospital. This center accepts addicts through civil commitment, from the criminal courts, from parole or probation authorities and on a voluntary basis offering a wide range of inpatient and aftercare services. Still in an embryonic stage, the program may well become a demonstration of what can be done for addicts. However, this program is limited to narcotics addicts and provides no hope for the harmful drug user.

RECOMMENDATIONS

119. Research efforts should be made to ascertain the number and geographic location of narcotics users.

120. All treatment and rehabilitative efforts and programs should include built-in research procedures.

121. Programs for narcotic addicts should be extended to include research and treatment of users of harmful drugs.

122. All community mental health programs should recognize drug addiction and harmful drug use as mental health problems. Active drug addiction treatment programs should be located in those community mental health centers situated in areas of high drug use.

It is recognized that those programs which function far from the geographically high-incidence areas of narcotic use will probably carry out little direct treatment of narcotics addicts. However, all community mental health programs should function as diagnostic, disposition, and referral centers for narcotics addicts. This will facilitate treatment, educational programs, follow-up and control. Programs should include both inpatient and outpatient facilities.

123. The need for continuing flexibility in treatment methods of drug addicts should be recognized.

Various types of treatment procedures, including the efficacy of maintaining addicts on stable dosages of drugs, should be investigated and evaluated under carefully regulated conditions.

124. Medical societies should be urged to review medical policies and treatment methods for drug addiction. Bar associations should be urged to review the legal aspects of the use of narcotics and harmful drugs, particularly in regard to federal and state laws, practices and procedures.

Such reviews should take place in cooperation with professional personnel involved in drug addiction treatment and research and in the light of accruing knowledge about the problem.

125. Efforts should be made to inform lawyers, judges and police and corrections personnel of the value, meaning and uses of the new drug addiction treatment and rehabilitation law.

126. Inpatient drug addiction treatment facilities should be physically separate, but physically adjacent to and administratively related to other inpatient facilities in community mental health programs.

The physical structure of an inpatient drug addiction treatment facility, with needs for security and control paramount, is different from other inpatient structures. In addition, specially trained personnel will be necessary in the drug addiction treatment program. Certain aspects of an inpatient program, such as occupational therapy and rehabilitation therapy, might be integrated with other inpatient facilities. Although the outpatient treatment facilities for drug addicts should be separate from other outpatient facilities, the physical needs of such an outpatient facility need no special consideration.

127. Various community resources and facilities, in addition to the state drug addiction treatment and rehabilitation program, should be explored with a view to their use in the treatment of drug addiction.

The activities of such facilities should be coordinated by the state treatment program. Efforts should be made to enlist all types of professional treatment and rehabilitative personnel in the treatment of drug addicts.

128. Joint treatment programs and collaborative rehabilitative efforts between police and corrections personnel and medical and social work personnel, both on administrative and individual case levels, should be encouraged and enhanced.

129. As knowledge about drug addiction accrues, efforts should be made to educate and inform hospitals, social agencies and other community facilities about the nature and treatment of drug addiction.

The purpose of such efforts, in addition to aiding community facilities in achieving greater treatment skill with drug addicts, is to lend support to these facilities and to enlist their cooperation in the treatment of drug addicts.

130. Programs of public education should be instituted concerning the nature of narcotic and harmful-drug use and addiction.

In addition to aiding the spread of knowledge about drug addiction, these programs will gain greater acceptance for treatment programs. In geographical areas of high incidence of drug addiction, programs should also be designed to enhance prevention.

EMOTIONAL NEEDS OF CHILDREN

It has been estimated that approximately 10% of the more than one million school-age children in Massachusetts are emotionally disturbed to the degree of requiring professional assistance. A problem of this magnitude requires a broad multi-level approach and the participation of all appropriate health, educational, and welfare resources. Citizens of Massachusetts have long been concerned with the problems of children and have established a variety of resources to cope with them. However, many gaps remain and new services are still urgently needed.

Prevention

Creating an environment conducive to positive mental health is considerably more difficult than creating one favorable to physical health. Nevertheless, a vigorous effort should be directed toward programs of primary prevention for children since this effort offers the greatest potential for ultimately reducing mental illness. It is possible to identify some of the forces impinging upon the child and influence the formation of a climate favorable to emotional development.

The family plays a central role in the development of positive emotional strengths. Although a great deal still remains to be learned about how this happens, we do know much which can be very useful if properly transmitted and accepted by the family.

There are many aspects of our highly competitive society that are healthy and desirable, but there are many which are extremely anxiety-provoking. To help children achieve a condition of vigorous enjoyment of the competitive life and a proper balance between the spiritual, ethical, educational and the material is an important task of positive mental health programs.

Schools have long been utilized to identify early problems. Because of their vital influence upon the growing child, schools can also become a major resource for primary prevention. In neighborhoods with high proportions of culturally and economically disadvantaged children, the school system provides a prime opportunity to work with these children and foster improved emotional development. Participation of mental health professionals in "Operation Headstart" can make significant contributions to the orientation of this program.

Many other opportunities exist for the expansion of primary prevention programs and they are enumerated in the recommendations.

Treatment Program

Emotionally disturbed children need a variety and range of treatment programs which can only be developed within the broad context of total community planning. The individual child generally needs a spectrum of carefully coordinated and integrated services. No part of the program is stronger than its weakest link.

Residential facilities are so inadequate that most of the children eligible for publicly supported treatment and education have to be sent outside of the state. The less than 100 beds now available in state facilities must be supplemented by a series of regional residential centers.

Day care treatment is the best procedure for certain children. Although relatively expensive, it is still less costly than the chronic hospitalization which otherwise might be necessary. As a result of the gross lack of group placement facilities and halfway houses, many children remain in settings highly unsuited for

them. Group placement programs are urgently needed, particularly for adolescents.

Special classes for emotionally disturbed children within the public school system are still inadequate, although their number is increasing. They provide only a small part of the resources needed and must be supplemented by clinic services.

Despite the growth of public facilities, private agencies will continue to play an important role in all aspects of care and treatment. Curtailment of either system would be detrimental to the general welfare of emotionally disturbed children.

Coordination of Services

An inevitable difficulty in developing a multifaceted program is lack of coordination between vested and disparate interests in various agencies. It is essential that the energies and activities of all programs dealing with children be harnessed in a manner which will lead to constructive cooperation.

On the statewide level, the Governor's Interdepartmental Committee on Children and Youth should increase its activities in coordinating the actions of all state agencies dealing with children. The Massachusetts Committee on Children and Youth should also establish a Mental Health Subcommittee to undertake various coordinative and consultative activities.

Role of the Department of Mental Health

Although programs of primary and secondary prevention require the participation of all community resources, the role of the Department of Mental Health will be crucial because of the numerous clinics it operates. Of even greater significance is the fact that only the Department of Mental Health has sufficient resources to conduct major research programs and to provide staff consultation to other community agencies.

Comprehensive community mental health programs will necessitate greater coordination and administrative linking of the Department of Mental Health's children and adult services. Needs and services for children are sufficiently unique to require the maintenance of children's units as discrete functional entities. However, both adult and children's units should be administratively responsible to the same local director and board rather than each functioning in isolation from the other.

The Department of Mental Health should also accept the responsibility for insuring that adequate standards are maintained in the provision of children's services for the development of training programs for professional and nonprofessional personnel and for undertaking active recruitment programs.

RECOMMENDATIONS

Prevention

131. Mental health professionals should cooperate with agencies offering premarital counseling in emphasizing positive attitudes toward pregnancy and family development.

132. Prenatal education of expectant mothers should include attention to emotional as well as physical factors.

133. Services of well baby clinics should be directed to the child's emotional as well as his physical development. Mental health consultation should be available to the staff of such clinics.

134. Special postgraduate courses in mental health should be offered to pediatricians so that they may continue to serve as a vital resource.

A survey of pediatricians indicated that 80% were interested in such postgraduate training.

135. Preschool nurseries and day care centers should be available for deprived children.

Services of these centers should focus upon the family as a unit and not just upon the child.

136. A curriculum which highlights the emotional development of children should be given strong emphasis in teachers' colleges.

137. A vigorous program of inservice training, centering about child development, should be made available to nursery, elementary, and parochial school teachers.

Local mental health centers should cooperate with colleges and universities in stimulating such programs.

138. The school consultation program of Department of Mental Health clinics should be expanded to focus upon curriculum as well as specific cases.

School psychologists and other mental health professionals should continue to work with teachers, school adjustment counselors, nurses, and other key personnel in the school system.

139. Mental health consultation should be available to all community resources which have significant interaction with children, such as, recreational centers, settlement houses and police departments.

Treatment

140. Research is urgently needed to develop briefer, more effective and less expensive modes of treatment.

Present treatment methods place a sharp limitation upon the number of children who can be given care.

141. Outpatient services for children should be provided in a variety of settings. All possible community resources should be utilized.

142. Outpatient departments of local general hospitals should be encouraged to include mental health services for children.

143. Special facilities such as day care and night centers are desperately lacking and should be expanded throughout the state.

144. Residential treatment programs for children should be established immediately in each of the state's six major regions.

The ultimate goal is the establishment of such programs, as needed, in each of the state's 37 planned mental health areas.

Coordination

145. The Governor's interdepartmental committee on children and youth should be assigned permanent staff.

Full time staff could help the committee function more effectively and assume a wider variety of responsibilities.

146. Every community should consider developing a central information and referral service.

This service could emerge from existing public or private facilities or it could be established by the local community council. Coordination of existing services is as vital as the development of new ones.

Department of Mental Health

147. Children's services should be administratively integrated into the community mental health program.

Although clinical services to children must be maintained as a functional entity, unified administration of children's and adult programs will enhance their respective efforts.

148. The Department of Mental Health should actively initiate and participate in training programs for professional and nonprofessional personnel.

EPILEPSY

Most Common Neurological Disorder

Epilepsy is defined as a physical condition resulting in the experience of seizures, regardless of whether they coexist with other neurological, non-neurological or psychiatric disorders. While epilepsy is not ordinarily considered mental illness, emotional aspects affect the frequency and severity of seizures in many cases. Therefore, epilepsy has sometimes been classed among the psychosomatic disorders.

These two conceptions of epilepsy, the strictly physical and the emotional-physical, are reflected in the fact that epilepsy care is delegated to public health as well as mental health departments throughout the country. By and large, the overwhelming majority of states in this country place the care of epilepsy among the responsibilities of departments of public health. In Massachusetts, perhaps because Monson State Hospital has historically been associated with the care and treatment of the epileptic, epilepsy has usually been classified as a responsibility of the Department of Mental Health. However, it should be recognized, that many professionals, from both the public health and mental health fields, believe that epilepsy should be the responsibility of the Department of Public Health in Massachusetts as is the case throughout most of the rest of the country.

Of the neurological disorders, epilepsy is the most common, involving from one-half to one percent of the population. Based on the 1960 census, it is estimated that there are 52,000 epileptic individuals in Massachusetts. Three out of every four epileptics experience their first seizure before the age of 20 with greatest incidence of seizure onset occurring among children before they reach the age of five. While one-fourth of the epileptics may have a combination of seizure types, almost two-thirds experience seizures of the grand mal type, characterized by brief loss of consciousness and uncontrolled clonic muscular spasms.

Medically Sound, But—

Problems confronting the epileptic are complex and contradictory. Through modern medical management, 80% of people with epilepsy benefit from total control or significant reduction of seizures. Yet, in Massachusetts, only 50% of those with epilepsy come forward (or as children are brought) for treatment. Nationally, this figure drops to a dismal 20%.

Exhaustive research has demonstrated that epileptics work productively and are not accident-prone; still, the mere past history of epileptic attacks often bars the door to employment. Studies conclusively prove that the intelligence of epileptics parallels that of the general population—some have very high I.Q.'s, some low, most normal; but schools and colleges are reluctant to accept the epileptic into the classroom or permit him to participate in regular school recreational and sports activities, and camps and community recreational facilities react similarly. Some people with epilepsy have social and emotional problems; yet the public and private agencies established for aiding people in such straits often bounce the epileptic applicant from one to another like a ping-pong ball.

Community understanding and community facilities are the requisites for equitable treatment of the epileptic in Massachusetts. With these goals in mind, the following recommendations are presented.

Recommendations

149. The Governor should establish a permanent advisory study committee on epilepsy.

It should include the Commissioners of Public Health, Mental Health, Education, Rehabilitation, and representative professional and lay leaders in the field of epilepsy. Their task would be to continually review and make recommendations for improved services to the epileptic in Massachusetts. One immediate task would be to review the present roles of the Departments of Mental Health and Public Health as the impetus for a possible new division of responsibility.

150. Present and future needs of Monson State Hospital should be examined in depth by an advisory study committee.

In addition to studying the treatment of epileptic children, the wider variety of handicapped children whose needs are partially met at this institution should also be investigated.

Also:

- Closer liaison between Monson and university and hospital teaching centers should be developed. The Department of Mental Health should review the professional staffing needs required to accomplish such a goal.
- Inpatient facilities and provisions for adequate schooling at Monson need to be expanded for epileptic children, as well as others, to adequately meet the present and future needs of the state.
- Hostel rooming-in facilities for parents of children hospitalized at Monson should be instituted on a pilot basis to promote the family participation required upon entrance and planned departure from an institution for children.
- Summer camping facilities of Camp Woodman for Monson children should be expanded so that more than the present 50 children could benefit from summer camping experiences. Further, either the state's Domestic Service Corps or trustees of the state or county correctional institutions should be solicited for the labor necessary to expand these facilities with a minimum cost for building materials.

151. A program to bring leading specialists in the field of epilepsy to general hospitals as consultants and teachers should be established.

These experts would provide postgraduate training in epilepsy for physicians and should increase the community's capacity to treat the epileptic near his home. It is further recommended that the Department of Mental Health take the initiative in establishing inservice training for personnel in state institutions, private agencies, and school health departments who are professionally involved with epileptics. One existing prototype of the required inservice training program is reflected in the present arrangement between the Wrentham State School and the Seizure Unit of the Children's Hospital Medical Center.

152. School systems should be encouraged to participate, particularly through their health and guidance departments, in a program of early identification and referral of epileptic children with emotional problems.

Psychological guidance, counseling services and medical treatment, regardless of a family's inability to pay, should be available.

153. No law or state regulation should require the central registration of epileptics in Massachusetts.

Because abuses outweigh the advantages of requiring a central registry of epileptics in the state, the current system of nonregistration should be continued.

154. A hospital rehabilitation center for epileptic patients should be established for those who need intensive medical and/or psychological treatment to achieve social independence.

As an initial step, the possibility of using the Lemuel Shattuck Hospital as a pilot project is suggested. This center should be associated with existing treatment centers and staff should have staff appointments. To encourage research and training, it should be affiliated with and located near medical and graduate schools.

155. A coordinator for epilepsy should be appointed by the Massachusetts Rehabilitation Commission.

Throughout the Commission's branches this person would be responsible for securing medical evaluations of the epileptic necessary for vocational planning, coordinating the efforts of social workers, consulting psychologists, and various specialists involved in assisting the vocational placement of epileptics, and working with potential employers in receiving information regarding jobs suitable for patients with seizures, and to develop a referral system related to these jobs.

156. Statistics report a relatively low rate of industrial accidents resulting from employment of epileptic workers. These statistics should be obtained and publicized.

157. Evaluation of the suitability of candidates subject to seizures to receive driving licenses should continue to be the responsibility of Board of Certified Neurologists, qualified and registered for practice in this state.

In the event of conflicting conclusions, adjudications should be made by an independent medical board or committee.

MENTAL RETARDATION

The Department of Mental Health has long been responsible for providing necessary clinical services for the mentally retarded and it has done so through four state schools and a series of pre-school nursery clinics. The North Reading Rehabilitation Center was opened in 1963 in a further effort to provide a resource in which the retarded could acquire skills necessary for community living.

Therefore a task force on mental retardation was organized in September, 1963 to consider the various needs of this group. The membership of the task force was multidisciplinary in that it was composed of not only mental health professionals but also individuals from all community programs which actually or potentially could contribute to the care of the retarded.

To achieve its goals, the task force organized itself into five committees dealing with the problem areas of residential programs, educational programs, professional services, community services and research. Each committee met frequently to analyze its specific area of concern and undertook whatever data collection or field visits seemed indicated.

In April, 1964 the Department of Mental Health was officially authorized to receive a $30,000 grant to undertake intensive and separate comprehensive planning for the mentally retarded. Under the terms of the Mental Retardation Planning Amendments of the 1963 Maternal and Child Health Act (Public Law 88-156) each state is to develop plans for services to the retarded based upon needs, administrative structure, progress in the field up to this point, and the potential for expanding services with present and anticipated resources.

The Massachusetts Mental Retardation Planning Project was organized in July, 1964, using the original task force as the nucleus around which it organized an expanded group for planning comprehensive services to the retarded. The Planning Project has established a firm basis for interdepartmental cooperation. The State Departments of Mental Health, Education, Public Welfare, Public Health, and the Rehabilitation Commission have appointed key officials for staff roles on the Project. Also, each of the above Departments is currently producing inventories of its current and planned services for the retarded, determining service gaps, and considering changes and additions both internally and in light of developments in other departments. These departmental studies will be integrated into the planning machinery of the Project. Also, an interdepartmental focus is assured inasmuch as the Planning Board which will be receiving the recommendations of the Project includes commissioners of 10 state departments and a member of the Special Legislative Commission on Mental Retardation. The Planning Board is chaired by the Commissioner of Public Health, Dr. Alfred L. Frechette.

The Project has also established close links with the Massachusetts Association for Retarded Children and prominent members serve on the planning board and the task forces.

Crucial Project decisions will be based on accumulated data and the knowledge and opinions of professionals and knowledgeable laymen throughout Massachusetts. To this end, nine task forces will deliberate with more than 100 individuals participating. Much time was devoted in the initial planning stages to careful selection of task force participants, developing guidelines for task force action, and thorough orientation of chairmen and staff. Currently, task forces on residential programs, education, prevention, community services, public and professional awareness, and manpower have completed their organization requirements and are operative. Task forces on research, law and legislation and administration will commence during the fall of 1965.

A great deal of interest has been aroused throughout the Commonwealth in the activities of the Mental Retardation Planning Project. An additional subsidy has been granted by the Department of Mental Health to supplement federal funds for calendar year 1965. Another demonstration of interest is the receipt of a maternal and child health federal subsidy through the Department of Public Health which was granted to the Harvard School of Public Health for work on the Project's prevention task force.

There is now pending before Congress legislation to extend state mental retardation planning projects for an additional two years. On the basis of an anticipated three-year schedule (1964-1967), the Mental Retardation Planning Project will prepare its final report for distribution in the summer of 1966. During the following, and final year, the Planning Project personnel will concentrate upon developing procedures necessary to implement key recommendations and will provide consultation in major areas of program development.

OCCUPATIONAL MENTAL HEALTH

The complexity of our modern industrial society has served to develop common interest in the problems of mental illness among management, labor and mental health workers. This development has been sharpened by factors such as these:

- The advent of rapid technological change and automation producing significant stress for affected individuals.
- The existence of "pockets of poverty" and the need for continuing job retraining necessitate concern for emotional factors since they involve the individual's capacity to adjust.
- In a recent year industrial accidents were responsible for 15,000 deaths and 2 million disabling injuries at an estimated cost of more than $3 billion. Estimates indicate that 70%-80% of these accidents were attributed to human origin, with a substantial proportion related to psychological factors.
- Alcoholism, employee dissatisfaction, turnover, absenteeism and poor work efficiency

are related to emotional factors and defy attempts at assessing their costs to the individual, his fellow employees and his company.

The problem of inadequate mental health programs related to occupations is national in scope. It is further accentuated in Massachusetts because industry tends to be small in size, with limited potential in any single organization for formulating a mental health program. Even more distressing has been the failure of the major academic training centers in Massachusetts to develop programs geared to the specific mental health needs of the industrial environment. Necessary constructive measures should be undertaken in education, prevention, early detection and the development of treatment facilities.

Educational Programs

Establishing mental health education programs for all levels of management and labor is beyond the ability of any local organization. The combined skills and energy of a larger group are required. Industry and labor should develop an Occupational Mental Health Council composed of representatives of industry, trade organizations, manufacturers' associations and labor councils. In this fashion concerted action by the top levels of management and labor can develop fruitful programs. This group could also serve to advise the Department of Mental Health on its occupational mental health activities.

Mental health associations should participate more actively in designing necessary programs for mental health seminars with business and union leaders. Educational programs must be specifically designed for blue-collar workers. Attitudes of workers toward emotional disturbances differ from that toward physical illness. In addition, the jargon of the mental health professions must be simplified and explained.

Programs of Prevention

Increasing recognition is being displayed by management and union leaders that the way people feel about themselves is directly related to their work. There is more awareness of the manner in which executives, supervisors and others in positions of authority influence the feelings and attitudes of their subordinates. Psychological and physiological symptoms can arise because of the behavior of supervisors. Conflict can be built into work situations by production schedules, work arrangements or the decision-making process.

Relations between environmental factors in the business world and the individual's predisposition toward mental illness require clarification. Before major preventive programs can be established, systematic research is necessary on the relation between job stress, environmental factors and human developmental factors.

Early Detection and Treatment

Since few firms have even the part-time services of a psychiatrist, responsibility for early detection must be assumed by other resources within industry. Depending upon the size of the firms, supervisors, foremen, shop stewards, personnel managers, industrial physicians and nurses could be trained to function in this capacity. Detection of early maladjustment is often possible through attention to signs such as sudden work errors, change in work habits, repeated accidents, absenteeism and interpersonal difficulties.

Treatment programs should be carried out in agencies staffed by professionals or private practitioners independent of the occupational setting. This separation would serve to assure both confidentiality and full concern for the individual consistent with the aims of treatment. Conflict of interest can be avoided through this arrangement.

Can industry continue to operate without explicit policies for insuring that psychiatric treatment is obtained by employees? Increased sophistication about early diagnosis, community treatment programs and crises approaches indicates that a fresh analysis should be undertaken by industrial management and unions in conjunction with mental health professionals.

Developing and Financing Treatment Facilities

In view of the current scarcity of treatment resources geared to adults with full-time employment, new community mental health centers should be located within easy access of major work centers. Evening and weekend appointments must be available.

The Department of Mental Health should enlarge its model of clinic and school relationships to apply to industry as well. Schools have developed effective procedures for making rapid referrals to clinics. Similar channels should be established allowing the personnel manager and industrial physician to make efficient use of local centers. In addition to the clinical services provided by the mental health center, regular mental health consultation could become an integral part of preventive programs within industry.

The involvement of local mental health centers with industry can only be accomplished through careful planning and direction. Industry and labor groups should increasingly participate on the boards of local mental health centers. An occupational mental health program should be created within the Department of Mental Health to provide leadership, stimulation and guidance to both industry and mental health facilities. Its purpose would not be supervisory or controlling.

In view of the great sums required to finance a comprehensive mental health program, costs must be borne by all segments of the economy. A variety of financial resources should be explored including the development of a per capita contractual arrangement between industry and the local mental health center.

Organized labor represents a powerful community resource which is pioneering in the development of comprehensive insurance coverage for mental illness.

RECOMMENDATIONS

158. Training programs should be developed within industry to sensitize key people to the importance of mental health and to the early signs of maladjustment.

These programs should work toward a better understanding of mental health problems and the resources to cope with these problems. Management, labor and employee groups should be included in an educational program elucidating the goals of early prevention and diagnosis.

159. Mental health professionals should greatly increase their participation in occupational mental health programs.

Few professionals are familiar with industry. Special training will be necessary to teach them the techniques and concepts relevant to the industrial environment.

160. Community mental health programs should work in close cooperation with local occupational settings.

Existing models of clinic and school relationships should be expanded to industry and labor organizations so that similar comprehensive coverage is provided for adults.

161. Clinical services for adults should be accessible to major work centers and should provide evening and weekend appointments.

162. A possible contractual arrangement between industry and the local mental health center should be explored in financing comprehensive programs.

163. A program of research is urgently required to gain fuller understanding of the relations between job stress, environmental factors and human developmental factors as they affect the individual's ability to function effectively.

164. An occupational mental health unit should be organized within the Department of Mental Health to plan and coordinate the development of appropriate programs in conjunction with business and unions.

165. A Massachusetts occupational mental health council should be organized to develop mental health education programs throughout the state.

The council should comprise representatives of industry, trade organizations, manufacturers' associations and labor councils.

166. As an integral part of their activities the Massachusetts Association for Mental Health and its local affiliates should develop educational programs for management personnel and union leaders.

RESEARCH

A Basic Attitude

Research activities have long been recognized as an integral component of any well-balanced mental health program. Research represents the attitude of inquiry basic to scientific activity and is utilized by clinicians, scientists and administrators to gain new knowledge and advance programs. Through research activities it has been possible to:

- Gain basic knowledge about the nature and cause of mental illness.
- Document and solidify the humanistic concepts which have guided the development of mental health programs and recently led to federal and state appropriations for community mental health centers.
- Carefully study and evaluate the various treatment modalities which periodically gain favor and disfavor.
- Expand the treatment armamentarium by initiating experimental and demonstration projects.
- Foster an intellectual climate in clinical facilities stimulating the acceptance and growth of new ideas.
- Encourage and retain highly qualified personnel.

The vitally urgent need for research was reflected in the recommendations of every study group that further investigation was necessary to produce more knowledge about the specific problem area. Furthermore, research is recognized by the National Institute of Mental Health regulations as one of the elements required in an adequate mental health service.

Extent of Current Studies

A survey of research projects, directed by personnel of the Department of Mental Health, identified at least 52 separate studies covering both theoretical and practical problems in progress during May 1964. Thirty-seven of the projects, or more than two-thirds of the Department's research, was sponsored by five facilities: Massachusetts Mental Health Center, Boston State Hospital, Worcester State Hospital, Medfield State Hospital, and Cushing Hospital. Only three of the 34 clinics affiliated with the Division of Mental Hygiene (South Shore, Lawrence, and Martha's Vineyard) indicated that research was actually in progress at the time of the survey.

Sources of Financial Support

Analysis of the research studies in terms of their budgets and sources of financial support revealed that during fiscal year 1963-1964 research budgets totaled

$2,302,569. Federal grants of $1,866,753 accounted for 81% of the total. The state contributed approximately $262,000 or 11% of the total. The remainder of the funds were obtained from private foundations and commercial sources.

It should be noted that the state's formal budget allocation of $262,000 for research is an amount that has remained unchanged for several years. A variety of clinical, personnel and overhead contributions which have been made available to researchers at the discretion of individual hospital administrators must be added to this sum.

These findings about formal budget support for research in Massachusetts assume significance when they are compared to developments elsewhere in the country. Although the specific sums allocated for research have remained static in Massachusetts, research expenditures have skyrocketed in other parts of the nation. Federal grants for mental health research have tripled from $42 million in 1959 to $122 million in 1963. In contrast during this specific period, research expenditures have remained static in Massachusetts even though the Department of Mental Health's budget increased from $59 million to $72 million. Consequently, research expenditures have actually decreased in terms of their proportion of the total mental health budget, from .44 of one percent in 1959 to .36 of one percent in 1963.

Administrative Difficulties Affecting Research

In spite of the central role research must play in advancing mental health programs, in many facilities it is considered tangential to the provision of clinical services. Consequently, policies and regulations have arisen which tend to hamper the effective operation of research programs. Researchers recognize that certain regulations are necessary for efficient management and control and, in fact, desire appropriate regulations for their own protection and ease of functioning. However, researchers object most strenuously to the increasing presence of inappropriate and irrelevant regulations. The operational difficulties encountered most frequently can be classified into two categories:

Regarding Positions

- Professional salaries in the Massachusetts Civil Service are unrealistically low in almost all categories of the mental health professions, despite recent pay raises.
- In contrast to their respected positions in universities, research investigators are accorded insufficient professional status in most clinical facilities.
- There are a lack of professional and subprofessional positions specifically earmarked for research.
- Persons can't be hired for many professional categories because of a lack of suitable job descriptions in the Civil Service system.
- There is no flexibility in the handling of funds for positions. The nature of research is such that modifications are necessary in the light of experience and in accordance with the availability of personnel.

Regarding Administrative Regulations

- The Department of Mental Health has no central office research director and communication between local facilities and the central office is very poor in regard to research matters.
- Researchers have an excessive amount of difficulty in receiving cooperation from other facilities. All Department of Mental Health facilities operate in a largely autonomous manner and no clear channels have been established for inter-institutional research cooperation.
- It is often very difficult to obtain clearance for unusual research procedures within a given institution, or to obtain the cooperation of necessary personnel.
- The collaboration of universities and other non-state agencies is difficult to maintain because of ambiguous regulations.

RECOMMENDATIONS

Research is an ongoing responsibility of the Department of Mental Health and this activity, as well as attitude, should be encouraged in all mental health facilities. Research must receive both administrative and financial support in the coming years, if for no other reason than to evaluate the new community mental health programs being developed throughout the state. Implementation of the following recommendations is imperative:

167. The level of formal budgetary support for research should be not less than 4% of the Department of Mental Health's budget.

If Massachusetts is to remain competitive with other parts of the country in attracting and retaining competent researchers, the level of formal budgetary support for research must be greatly increased from its present low level of only .36%. The report of the Joint Commission on Mental Illness and Health indicated that progressive states were allocating 4% of their mental health budgets to research. Industry routinely devotes 5% to research and development.

It is not only the limited amount of funds that has created difficulty but also their manner of distribution. Funding procedures must be modernized and appropriations not budgeted in as restrictive a manner as they are currently.

168. Research programs require a separate identity within the central office and various facilities of the Department of Mental Health.

The present Division of Medical Statistics and Research performs valuable specific functions in collecting, analyzing, and reporting necessary statistical information. In view of its limited personnel and specific functions, this Division is not responsible for the broad ranging needs of researchers.

A coordinator of mental health research in the central office of the Department of Mental Health is necessary to facilitate the activities of researchers in all state facilities. He should assume responsibility for the problems and interests of researchers at the statewide level and provide liaison between the central office and local facilities. Most important of all, he should stimulate research in the majority of state facilities which currently do not have a single research project in progress.

169. The Department of Mental Health should submit new job descriptions for research positions to Civil Service so that a wide variety of individuals could be recruited.

Suitable job descriptions are currently lacking for many professional and technical categories.

170. A central, non-profit research corporation should be established to receive and administer state, as well as non-state, mental health research funds.

A central corporation is legally necessary to receive state and non-state research funds. Regulations and methods of procedure should be established enabling the researcher to function in a responsible, yet effective and flexible manner. The corporation should be guided by a board of trustees composed of persons from various specialties affiliated with academic, clinical and other institutions. The executive director, who could also be the coordinator of research for the Department of Mental Health, could be responsible for administering the corporation.

Existing research corporations, which are local in scope and range of interest, should not be dissolved immediately. A successful central research corporation would eventually obviate the need for private corporations at individual facilities.

Appendix A

Advisory Council

Rev. Joseph T. Alves, D.S.W.	Family Counseling and Guidance Centers, Inc.
Robert Arnot, M.D.	Association of General Hospital Psychiatrists
Bernard Bandler, M.D.	Boston University School of Medicine
James Marvin Baty, M.D.	Massachusetts Medical Society
William Belanger	Massachusetts Division of Employment Security
Chester Bennett, Ph.D.	Boston University
S. Bruce Black	Liberty Mutual Insurance Company
Mrs. Frederick J. Blizard	Massachusetts Department of Public Health
Mrs. Rudolph Bruce	Massachusetts League of Women Voters
Morris E. Chafetz, M.D.	Massachusetts General Hospital
Richard Chapman	New England Merchants National Bank
C. Raymond Chase	United Community Services of Metropolitan Boston
William H. Chasen, M.D.	Veterans Administration
Sidney Q. Curtiss	State Representative, Sheffield
Maurice A. Donahue	State Senator, Holyoke
James Dunning, D.D.S.	Harvard School of Dental Medicine
Abbie E. Dunks	Lexington
Jack Ewalt, M.D.	Massachusetts Mental Health Center
Dana L. Farnsworth, M.D.	Harvard University Health Service
Malcolm J. Farrell, M.D.	Walter E. Fernald State School
John G. Fettinger	National Association for Retarded Children
Bardwell H. Flower, M.D.	Worcester State Hospital
J. John Fox, Esq.	Norfolk County Probate Court
Joseph Freedman	Legislative Commission on Retardation
Benjamin Friedman	Mayor of Taunton
George E. Gardner, M.D., Ph.D.	Children's Hospital Medical Center
James M. Gavin	Arthur D. Little Company
Sydney S. Gellis, M.D.	Tufts-New England Medical Center
Robert J. Glaser, M.D.	Affiliated Hospitals Center, Inc.
Donald Guild	Massachusetts Association for Retarded Children
Robert Hamlin, M.D.	Harvard University School of Public Health
C. Edward Holland	Boston Record American
Leston L. Havens, M.D.	Massachusetts Mental Health Center
Pliny Jewell, Jr.	Massachusetts Association for Mental Health
Marvin T. Karger	Food and Merchandise Vending Corporation
Very Rev. Monsignor George V. Kerr	Chaplain, Senate, Commonwealth of Massachusetts
Rabbi Joseph Klein	Temple Emanuel, Worcester
John Lederle, Ph.D.	University of Massachusetts
Erich Lindemann, M.D.	Massachusetts General Hospital
Mary Maher, R.N.	University of Massachusetts

James M. McCracken, Jr.	Eastern Massachusetts Chapter, National Association of Social Workers
Arthur H. MacKinnon	Massachusetts Department of Corporations and Taxation
Paul G. Myerson, M.D.	Tufts University School of Medicine
Thomas O'Connor, Esq.	O'Connor, Martinelli and Smith
Howard Parad	Smith College, School for Social Work
Rev. Albert J. Penner, D.D.	Massachusetts Council of Churches
Calvin H. Plimpton, M.D.	Amherst College
John E. Powers	Clerk, Supreme Judicial Court for Suffolk County
William Price, M.D.	Roxbury
Anne Roe, Ph.D.	Center for Research in Careers, Harvard University
Charles I. Schottland	Brandeis University
Robert S. Schwab, M.D.	Massachusetts General Hospital
Lamar Soutter, M.D.	University of Massachusetts
Joseph Slavet	Action for Boston Community Development
*Harry C. Solomon, M.D.	Massachusetts Department of Mental Health
Richard C. Steele	Worcester Telegram, The Evening Gazette
Richard Stetson, M.D.	Veterans Administration
**John F. Thompson	State Representative, Ludlow
Mrs. Irene K. Thresher	Massachusetts Association for Mental Health
F. Frank Vorenberg	Gilchrist's
William Waldron, Esq.	Boston
Joseph Weinreb, M.D.	Worcester Youth Guidance Center
Lewis Weinstein, Esq.	Foley, Hoag and Eliot
Nils Y. Wessell, Ph.D.	Tufts University
James Q. Wilson, Ph.D.	Joint Center For Urban Studies of Massachusetts Institute of Technology and Harvard University
George A. Wolf, Jr., M.D.	Tufts University School of Medicine

* Chairman

** Deceased

Appendix B

Members: First year task forces

Adult Crime and Juvenile Delinquency

Co-Chairmen: Raymond Gilbert, Ph.D., Massachusetts Department of Correction; Paul K. Connolly, Judge, District Court, Waltham

Saul Bernstein	Boston University, School of Social Work
Harold D. Bryant	Massachusetts Society For Prevention of Cruelty to Children
*Patrick E. Callaghan	State Representative, Pittsfield
Mrs. Gertrude Cuthbert	Action For Boston Community Development
Warren P. Cordes, M.D.	Gardner State Hospital
Anthony DeNatale	Probation Officer, District Court, Cambridge
John Fitzpatrick	Massachusetts Correctional Institute, Walpole
John L. Forbes	Dennison House
John A. Gavin	Massachusetts Correctional Institute, Walpole
Francis J. Kelly, Ed.D.	Division of Youth Service
Thomas J. Maguire	Woburn Police Department
Elizabeth Makkay, M.D.	Judge Baker Guidance Clinic
Edward J. McCormack, Jr.	Boston
John McMillan	Worcester Telegram-Evening Gazette
Paul C. Menton	State Representative, Watertown
John Moran	United Prison Association of Massachusetts
Norman Neiberg, Ph.D.	Massachusetts Department of Mental Health
Frank Ordway	Youth Detention Center, Worcester
William F. Otis	State Representative, Boston
Rev. Arthur Rice	Reception-Detention Center for Boys, Roslindale
Catharine V. Richards, D.S.W.	Law-Medicine Research Institute, Boston University
Mark Richmond	Massachusetts Council on Crime and Delinquency
Reginald Robinson, Ph.D.	Massachusetts Committee on Children and Youth
Donald Hayes Russell, M.D.	Massachusetts Department of Mental Health

Elliott Sands	Massachusetts Board of Probation
Sylvia Sherwood, Ph.D.	Tufts University
Mrs. Betty Cole Smith	Massachusetts Correctional Institute, Framingham
Samuel Tartakoff, M.D.	Massachusetts Department of Mental Health
Cornelius J. Toomey	Massachusetts Parole Board
Donald P. Tulloch	Sheriff, Barnstable County

Affiliations are listed only for purposes of identification. Each person served as an individual.

* Deceased

Adult Mentally Ill

Co-Chairmen: Philip Solomon, M.D., Harvard Medical School; Donald Moreland, Family Service Association of Greater Boston

John A. Armstrong	State Representative, Plymouth
John Arsenian, Ph.D.	Boston State Hospital
Libbie B. Bower, Ph.D.	Massachusetts Association for Mental Health
Murray Cohen, Ph.D.	Boston University
Jack Consenstein	Roxbury Community Council
Francis de Marneffe, M.D.	McLean Hospital
Alice Dempsey, R.N.	Visiting Nurse Association of Boston
Leston Havens, M.D.	Massachusetts Mental Health Center
Louisa Howe, Ph.D.	Harvard School of Public Health
Robert Hyde, M.D.	Massachusetts Department of Mental Health
John Larson, M.D.	Springfield
Theodore Lindberg, M.D.	Medfield State Hospital
Erich Lindemann, M.D.	Massachusetts General Hospital
Charles J. Littlefield	Public Assistance, Cambridge
George Macomber	Cambridge Trust Company
William Malamud, M.D.	Boston University School of Medicine
Reuben Margolin, Ph.D.	Northeastern University
Dorothy Mathews	Boston State Hospital
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David W. Moriarty, M.D.	Worcester State Hospital
Thomas Pugh, M.D.	Massachusetts Department of Mental Health
Philip Quinn, M.D.	St. Elizabeth's Hospital
Most Rev. Thomas J. Riley	Auxiliary Bishop of Boston
Morris Schwartz, Ph.D.	Brandeis University
Elvin Semrad, M.D.	Massachusetts Mental Health Center
Leon N. Shapiro, M.D.	Tufts University School of Medicine
Lewis J. Sherman, Ph.D.	Brockton Veterans Administration Hospital
Mrs. Lilly Siskind	Greater Lawrence Guidance Center, Inc.
Rev. William P. Sullivan	Metropolitan State Hospital
Samuel Tarnower, M.D.	Pittsfield
John J. Toomey	State Representative, Cambridge

Aging

Co-Chairmen: J. Sanbourne Bockoven, M.D., Cushing Hospital; Mary E. Shaughnessy, R.N., Boston College, School of Nursing

Secretary: Esther C. Cook, Brookline Association for Mental Health, Inc.

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David Blau, M.D.	Newton
Mario Carbone	Cushing Hospital
Frithiof Carlson	Keith Hill Nursing Home
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Harry Karpeles	Massachusetts Rehabilitation Commission
Bernard Kramer, Ph.D.	Tufts University School of Medicine
Rev. Roland Samuel Larsen	First Congregational Church, Cambridge
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Francis Looney	Massachusetts Council for the Aging
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Joseph D. Murphy	Public Assistance, Lynn
Robert Ott	Massachusetts Department of Public Welfare
Harry T. Phillips, M.D.	Massachusetts Department of Public Health
Mary Louise Reilly	Brockton
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Richard Steinman	Brandeis University
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Alcoholism

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Frederick Clarke	Salvation Army, Springfield
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W. Everett Glass, M.D.	Taunton State Hospital
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Drug Addiction

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* Deceased

Epilepsy

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George O'Shea	Division of Youth Service
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J. Whitney Brown, M.D.	American Academy of General Practice
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Donald Guild	Massachusetts Association for Retarded Children

George Gulick	Worcester Association for Retarded Children
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William J. O'Brien	Massachusetts Department of Education
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William Perry	Greater Boston Association for Retarded Children, Inc.
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Dorothy Singer, Ph.D.	Massachusetts Rehabilitation Commission
Paul Solomon, Ph.D.	Bristol County Mental Health Clinic
Leon Sternfeld, M.D.	Massachusetts Department of Public Health
Edward Zelazo	State Representative, Adams

Occupational Mental Health

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Joel Johnson, M.D.	Boston Edison Company
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Robert Palmer	Polaroid Corporation
James Roberts, M.D.	New England Electric System
Irving Sanders	Norfolk Mental Health Association
John T. Shea, M.D.	Foxborough State Hospital
George Spencer, M.D.	New England Telephone and Telegraph Co.
*Jack Teger	Polaroid Corporation

* Deceased

Research

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Harry Freeman, M.D.	Medfield State Hospital
Howard Freeman, Ph.D.	Brandeis University
Marc Fried, Ph.D.	Massachusetts General Hospital
Chester Keefer, M.D.	University Hospital
Ogden R. Lindsley, Ph.D.	Metropolitan State Hospital
Ralph R. Nottman, M.D.	Boston State Hospital
Leslie Phillips, Ph.D.	Worcester State Hospital
Thomas Pugh, M.D.	Massachusetts Department of Mental Health
Thomas Ritchie	Worcester Area Mental Health Association
Sheldon Roen, Ph.D.	South Shore Guidance Center
John F. Scott, Ph.D.	Worcester Youth Guidance Center
Hans-Lukas Teuber, Ph.D.	Massachusetts Institute of Technology

Training

Co-Chairmen: Bernard Bandler, M.D., Boston University School of Medicine
Rita Kelleher, R.N., Boston College, School of Nursing

Chester C. Bennett, Ph.D.	Boston University
Edwin D. Driver, Ph.D.	University of Massachusetts
James W. Dykens, M.D.	Massachusetts Department of Mental Health
George Gardner, M.D., Ph.D.	Judge Baker Guidance Center
Rebecca Glasmann	Bedford Veterans Administration Hospital

Peter B. Hagopian, M.D.	Danvers State Hospital
Mrs. Lillian S. Irvine	Massachusetts Department of Mental Health
Jerry A. Johnson	Boston University
Edward Kovar	United Community Services of Metropolitan Boston
Paul Meyerson, M.D.	Tufts University School of Medicine
John Nemiah, M.D.	Harvard Medical School
Talcott Parsons, Ph.D.	Harvard University
Robert F. Rutherford	Simmons College School of Social Work
Virginia Senders, Ph.D.	New England Board of Higher Education
Walter Tucker, M.D.	Lahey Clinic
Morton Wiener, Ph.D.	Clark University

Members: Second year task forces

Administration

Chairman: George A. Wolf, Jr., M.D., Tufts University

Herbert Aptekar, D.S.W.	Brandeis University
Joseph Courtney	Boston University
Abbie E. Dunks	Lexington
James Dykens, M.D.	Massachusetts Department of Mental Health
Bellenden R. Hutcheson, M.D.	Massachusetts Department of Mental Health
William F. McLaughlin, M.D.	Metropolitan State Hospital
Robert Moore, M.D.	Massachusetts Department of Mental Health
Steven Rosner	Massachusetts Association for Mental Health
Robert VanWart	The Community Council, Inc., Springfield
James Wilson, Ph.D.	Joint Center For Urban Studies of Massachusetts Institute of Technology and Harvard University

Community Mental Health Programs

Chairman: Jack Ewalt, M.D., Massachusetts Mental Health Center

Rev. Joseph Alves, D.S.W.	Family Counseling and Guidance Centers, Inc.
Robert Arnot, M.D.	Association of General Hospital Psychiatrists
Libbie Bower, Ph.D.	Massachusetts Association for Mental Health
Gerald Caplan, M.D.	Harvard Medical School
Saul Cooper	South Shore Mental Health Center
Bardwell Flower, M.D.	Worcester State Hospital
Bellenden R. Hutcheson, M.D.	Massachusetts Department of Mental Health
Erich Lindemann, M.D.	Massachusetts General Hospital
Howard Parad	Smith College, School of Social Work
John L. Quigley	Massachusetts Hospital Association
William Ryan, Ph.D.	Massachusetts Committee on Children and Youth
Philip Solomon, M.D.	Harvard Medical School
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Financing

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Mrs. Frederick J. Blizard	Massachusetts Department of Public Health
Arthur G. Carty	Blue Cross-Blue Shield
Bright Dornblazer	Franklin County Hospital
Joseph P. Gentile	Massachusetts Department of Mental Health
Edward Kovar	United Community Services of Metropolitan Boston
Elwyn E. Mariner	Massachusetts Federation of Taxpayers Associations, Inc.
Alfred Olerio	Massachusetts Labor Council, AFL-CIO
Daniel Ray	Massachusetts Department of Mental Health
Benjamin Rosenberg, Ph.D.	Combined Jewish Philanthropies of Greater Boston
A. M. Wilson	Liberty Mutual Insurance Co.

Appendix C

Total Population and Age Composition

Mental Health Area Populations				Age Composition (1960)											
				Under 5		5-14		15-24		25-54		55-64		65 and over	
Area	1960 Population	1970 Projection	1960 Median Age	No.	Rate[1]	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Barnstable	95,067	105,447	31.6	11,167	11,746	16,833	17,706	12,117	12,746	33,657	35,403	8,981	9,447	12,312	12,951
Berkshire	142,135	155,324	31.8	15,446	10,867	27,011	19,004	16,478	11,593	53,607	37,716	13,553	9,535	16,040	11,285
Boston State	230,187	230,187	33.5	23,060	10,018	38,629	16,728	29,290	12,724	85,068	36,964	26,508	11,516	27,614	11,996
Boston University	158,065	158,065	34.1	15,331	9,699	22,927	14,505	22,868	14,467	59,154	37,424	17,434	11,030	20,351	12,875
Brockton	185,410	235,500	30.1	23,129	12,475	36,527	19,701	21,218	11,444	69,716	37,601	15,168	8,181	19,652	10,599
Cambridge	202,413	188,000	31.3	19,823	9,793	29,175	14,413	36,453	18,009	73,670	36,396	20,433	10,095	22,859	11,293
Concord	37,868	51,500	28.9	5,030	13,283	7,982	21,078	3,935	10,391	14,917	39,392	2,725	7,196	3,279	8,659
Danvers	208,442	243,200	31.9	23,220	11,140	39,293	18,851	22,904	10,988	80,329	38,538	19,328	9,273	23,368	11,211
Fall River	131,734	139,486	33.1	12,518	9,502	23,560	17,884	16,175	12,279	50,905	38,642	13,882	10,538	14,613	11,093
Fitchburg	148,623	168,679	28.3	17,185	11,563	27,408	18,441	23,706	15,950	54,106	36,405	11,711	7,880	14,227	9,572
Foxborough	66,622	82,500	30.4	7,660	11,498	12,864	19,309	8,263	12,403	24,692	37,063	5,785	8,683	7,358	11,044
Franklin	54,864	61,585	32.5	5,653	10,304	11,019	20,084	5,743	10,468	19,977	36,412	5,181	9,443	7,291	13,289
Gardner	45,885	51,083	33.1	4,651	10,136	8,534	18,598	5,148	11,219	17,048	37,154	4,623	10,075	5,881	12,817
Government Center	185,180	181,048	32.8	17,488	9,444	30,193	16,305	26,126	14,108	71,953	38,856	18,414	9,944	21,006	11,344
Grafton	83,438	85,824	31.7	9,068	10,868	16,144	19,348	9,336	11,189	32,167	38,552	8,028	9,622	8,695	10,421
Haverhill	93,760	99,600	33.2	9,876	10,533	17,157	18,299	10,584	11,288	33,951	36,211	9,516	10,149	12,676	13,520
Holyoke	153,123	168,927	30.4	16,609	10,847	28,630	18,697	20,720	13,532	58,150	37,976	13,751	8,904	15,263	9,968
Lawrence	125,833	130,000	33.8	12,252	9,737	22,788	18,110	13,966	11,099	47,890	38,058	13,045	10,367	15,892	12,629
Lowell	177,542	215,800	29.5	21,990	12,386	35,946	20,246	20,906	11,775	66,311	37,349	14,945	8,418	17,444	9,825
Lynn	140,796	148,500	27.4	14,295	10,153	25,799	18,327	15,961	11,336	53,296	37,853	14,422	10,243	17,023	12,090
Malden	166,191	158,000	32.9	16,535	9,949	28,165	16,947	21,912	13,185	62,652	37,699	17,923	10,785	19,004	11,435
Massachusetts Mental Health Center	205,992	202,948	36.0	15,808	7,674	25,330	12,297	34,834	16,910	73,932	35,891	26,943	13,080	29,145	14,149
Medfield	157,507	209,000	29.5	19,347	12,283	33,102	21,016	16,834	10,688	62,220	39,503	12,663	8,040	13,360	8,482
Metropolitan	123,220	129,000	32.8	12,936	10,498	20,694	16,794	15,856	12,868	46,917	38,075	13,455	10,911	13,362	10,844
Mystic Valley	152,055	195,500	30.9	18,802	12,365	29,488	19,393	16,017	10,534	59,774	39,311	13,942	9,169	14,032	9,228
New Bedford	138,803	146,119	34.4	12,928	9,314	24,105	17,366	15,681	11,297	53,065	38,230	15,121	10,894	17,903	12,898
Newton	126,716	133,500	31.6	10,855	8,566	23,920	18,877	18,318	14,456	46,885	37,000	13,781	10,876	12,957	10,225
Northampton	55,439	61,578	28.9	4,680	8,442	8,444	15,231	12,136	21,891	18,558	33,475	5,192	9,365	6,429	11,597
Plymouth	37,911	50,653	32.4	3,981	10,501	7,309	19,279	4,233	11,166	13,915	36,704	3,730	9,839	4,743	12,511
Reading	99,325	116,500	31.0	11,294	11,370	20,169	20,306	10,772	10,845	37,919	38,177	9,125	9,187	10,046	10,114
Southbridge	100,679	119,392	31.8	10,372	10,302	19,246	19,116	11,831	11,751	39,332	39,067	9,136	9,074	10,762	10,689
South Shore	251,417	296,000	30.4	28,603	11,377	50,793	20,203	29,000	11,535	94,846	37,725	23,248	9,247	23,927	9,517
Springfield	296,799	326,838	31.5	33,412	11,257	56,907	19,174	33,555	11,306	114,212	38,481	27,315	9,203	31,398	10,579
Taunton	78,286	88,857	31.9	8,247	10,534	14,563	18,602	9,520	12,161	29,733	37,980	7,496	9,575	8,727	11,148
Tufts	57,557	57,557	29.4	6,832	11,870	11,243	19,534	7,777	13,512	20,169	35,042	5,115	8,887	6,421	11,156
Westborough	167,974	232,800	29.1	22,902	13,634	34,881	20,766	17,086	10,172	66,010	39,298	12,433	7,402	14,662	8,729
Worcester	257,307	291,057	32.9	25,555	9,932	45,374	17,634	32,639	12,685	95,683	37,186	26,494	10,297	31,562	12,266
TOTALS	5,140,186	5,715,554	31.8	548,540	10,672	932,452	18,140	650,961	12,664	1,936,404	37,672	500,545	9,738	571,284	11,114

[1] Per 100,000 population

(Data obtained from 1960 U. S. Census Report.)

Appendix D

Intercorrelation of Priority Index Factors

	Less $3,000	*Unemplyd.*	*Val. Hsng.*	*% Deter.*	*Mdn. Yrs. Educ.*	*Less 5 Yrs. Educ.*	*M.H. Adm.*	*M.R.*	*P.H.*	*Arrsts.*	*Y.S.B.*	*Drunk.*	*Narc.*	*OAA*	*MAA*	*DA*	*ADC*	*GR*
Median Income	89	75	77	70	75	64	15	51	—07	26	63	51	14	65	49	63	54	58
Less $3,000		68	55	72	63	62	10	55	01	42	71	65	16	72	59	71	65	67
Unemployed			65	57	65	60	—01	50	23	23	55	47	19	65	53	54	56	72
Mdn. Val. Hsng.				54	69	40	16	47	—07	—03	33	20	—18	38	21	31	25	49
% Deteriorated					65	53	00	46	08	39	58	64	14	66	55	66	57	73
Mdn. Yrs. Educ.						76	—01	42	—08	11	53	35	—15	60	40	58	40	63
Less 5 Yrs. Educ.							05	36	12	28	60	38	—05	52	44	59	50	47
M. H. Admissions								10	—32	06	—01	34	23	10	00	07	—05	—03
Ment. Retarded									—05	08	40	45	15	48	37	43	48	46
Phys. Hdcpd.										15	07	03	08	—05	05	—08	11	10
Arrests											61	68	42	41	46	49	59	41
Y. S. B. Commit.												65	41	69	73	77	79	58
Drunkenness													50	69	60	69	68	61
Narcotics														28	39	27	34	13
OAA															86	49	83	70
MAA																90	85	45
DA																	86	60
ADC																		62

d.f. = 35; $r_{.05} = .325$; $r_{.01} = .42$

Priority Index Factors

Median income per family
Number of families having an income of less than $3,000
Unemployment in the civilian labor force
Median value of one-unit housing
Percentage of total housing units considered deteriorating or dilapidated
Median years of education completed by people over 25
Number of people over 25 with less than 5 years of education
Number of admissions to mental hospitals 1958-61
Number of mentally retarded children in special education classes
Number of physically handicapped children in special education classes
Total number of arrests by local and state police
Number of commitments to Youth Service Board facilities
Number of arrests for drunkenness
Number of arrests for violation of 1963 Narcotics Law
Number of recipients of old age assistance
Number of recipients of medical aid to aged
Number of recipients of disability assistance
Number of recipients of aid to dependent children
Number of recipients of general relief

Appendix E

Socioeconomic Indicators

Area	Income Levels: Median Income	Rank	Less Than $3,000	%	Rank	Unemployed. No.	Rate Per 100,000[1]	Rank	Housing: Median Value	Rank	% Deteriorating and Dilapidated	Rank	Education: Median Years Completed	Rank	Less Than Five Years: No.	Rate[3]	Rank
Barnstable	$5,270	5	4,642	18.8	4	787	5,427	9	$11,600*	7.5	10.5*	25	12.0	29.5	1,883	3,427	32
Berkshire	6,138	21	5,041	13.7	13	2,025	4,593	14	13,000*	17	17.1*	7	11.0	17	4,181	5,025	20
Boston State	6,457	26	5,988	10.3	25.5	3,401	3,543	24	13,500[2]	23	8.4	29	11.6	25	9,063	6,510	10
Boston University	5,008	2	8,954	25.6	1	4,537	6,216	2	13,500[2]	23	33.8	1	10.4	11	8,430	8,696	5
Brockton	6,228	23	4,757	10.3	25.5	3,253	4,575	15	12,300	12.5	11.3	23	11.6	25	4,826	4,617	27
Cambridge	5,970	15	6,638	12.2	20	3,359	3,776	21	12,600	14	13.8	13.5	11.5	23	7,032	6,012	16
Concord	7,996	36	705	7.5	33	214*	1,757	37	18,600*	34	8.0*	32	12.2	32.5	959	4,584	28
Danvers	6,590	29	6,051	11.4	23	2,810	3,364	25	14,900	28	12.3	20	11.6	25	5,701	4,634	26
Fall River	5,181	4	6,539	18.4	5	3,272	5,835	4	11,200	6	14.5	10	8.7	2	9,232	11,627	2
Fitchburg	5,847	11	4,645	12.8	17	1,116	2,979	29	11,700*	9	19.3*	5	10.8	14	3,960	4,947	21
Foxborough	6,182	22	1,592	8.8	29	818	3,314	26	11,800*	10	12.2*	21	10.8	14	1,274	3,367	33
Franklin	5,430	6	2,352	16.5	7	516*	4,358	16	11,000*	4	12.7*	17.5	11.4	24.5	1,355	4,176	30
Gardner	5,541	7	1,743	15.0	10	406*	5,487	8	10,300*	2	13.9*	12	9.9	4	1,909	6,929	8
Government Center	5,604	8	7,865	17.0	6	4,533	3,165	28	13,400[2]	20.5	19.1	6	10.3	10	12,374	11,110	3
Grafton	5,959	14	2,357	10.9	24	1,260	4,198	17	12,000*	11	12.7*	17.5	10.0	6.5	2,915	5,962	18
Haverhill	6,006	16	3,329	13.6	14	1,898*	5,787	5	11,000*	4	20.4*	4	10.8	14	2,772	4,937	22
Holyoke	6,063	18	4,690	12.2	20	2,492*	5,749	6	12,700*	15	8.6*	28	10.1	9	5,401	6,194	14
Lawrence	6,067	19	5,028	15.1	8.5	2,031	3,731	23	14,500	26	15.8	9	10.0	6.5	6,608	8,601	6
Lowell	6,112	20	3,765	9.0	28	3,180	4,741	12	12,300	12.5	21.9	3	10.6	12	4,828	4,892	24
Lynn	6,568	28	4,560	12.4	18	1,378	2,394	32	14,600	27	12.6	19	11.4	24.5	4,132	4,876	25
Malden	6,334	24	4,388	10.0	27	2,767	3,936	20	14,300	25	9.8	27	11.3	19.5	6,034	6,060	15
Massachusetts Mental Health Center	6,495	27	6,550	13.0	15.5	3,683	3,768	22	21,000[2]	36	10.2	26	11.8	28	5,111	3,931	31
Medfield	7,543	34	2,542	6.6	35	1,499	2,596	31	15,400	30	7.8	33	12.2	32.5	2,958	5,280	19
Metropolitan	7,250	30	2,415	7.7	32	1,402	2,682	30	18,600	35	4.6	35.5	12.0	29.5	3,348	4,541	29
Mystic Valley	7,924	35	2,329	6.2	36	1,186	2,071	35	18,200	33	4.6	35.5	12.4	36	2,268	2,585	36
New Bedford	5,179	3	7,608	20.4	3	2,903*	6,499	1	11,000	4	12.1	22	8.6	1	10,957	12,728	1
Newton	9,913	37	1,789	5.8	37	991	1,967	36	23,800	37	4.1	37	13.0	37	2,158	2,931	35
Northampton	5,832	10	1,748	15.1	8.5	531*	3,306	27	12,800*	16	13.7*	15	11.3	19.5	2,220	7,356	7
Plymouth	5,905	12	1,440	14.5	11	646*	5,631	7	13,300*	19	15.9*	8	11.7	27	1,099	4,909	23
Reading	7,382	33	1,787	7.1	34	841	2,170	33	16,200	31	7.0	34	12.3	34.5	1,069	1,872	37
Southbridge	5,932	13	3,053	11.7	22	1,467	4,686	13	11,600*	7.5	10.6*	24	9.7	3	3,854	6,507	11
South Shore	7,252	31	4,960	7.8	30.5	3,993	4,131	18	15,300	29	8.2	30	12.3	34.5	3,391	6,003	17
Springfield	6,425	25	9,322	12.2	20	5,929*	5,163	11	13,400*	20.5	15.4*	10	11.2	18	10,836	6,266	12
Taunton	5,671	9	2,820	14.4	12	1,070*	5,187	10	10,200*	1	13.0*	16	10.0	6.5	3,050	6,637	9
Tufts	4,908	1	2,955	22.1	2	1,347	6,158	3	13,500[2]	23	27.3	2	10.0	6.5	3,148	9,929	4
Westborough	7,363	32	3,256	7.8	30.5	1,270	2,117	34	16,500	32	8.1	31	12.1	31	2,818	3,027	34
Worcester	6,046	17	8,777	13.0	15.5	3,984*	4,010	19	13,100	18	13.8	13.5	10.9	16	9,540	6,205	13
TOTALS	$6,272		158,980	13.0		79,771	4,145		13,800		13.0		11.6		172,694	5,741	

* Information not available for some towns within area.

[1] In the civilian labor force.

[2] Estimate based upon entire City of Boston

[3] Per 100,000 people over 25 years of age.

(Data obtained from 1960 U. S. Census reports.)

Appendix F

Measures of Mental and Physical Illness

Area	Number of First Admissions to Mental Hospitals 1958-1961[1]								Disability[2]					
						Total			Mentally Retarded			Physically Handicapped		
	State	Private	V.A.	Ratio S-P*	Rank	No.	Rate[3]	Rank	No.	Rate[3]	Rank	No.	Rate[3]	Rank
Barnstable	457	62	18	7.37	10	537	565	6	224	236	13	371	390	36
Berkshire	270	21	26	12.86	4	317	223	37	204	144	33.5	1,163	818	9
Boston State	270	228	60	1.18	31	558	242	36	454	197	21	2,000	869	7.5
Boston University	618	168	87	3.68	16	873	552	7	675	427	1	1,278	809	10
Brockton	567	143	94	3.97	14	804	434	19	515	278	6	1,435	774	11
Cambridge	668	446	102	1.50	25.5	1,216	600	4	388	192	23	1,015	501	29
Concord	94	63	10	1.49	27	167	441	16.5	29	77	37	157	415	35
Danvers	751	104	52	7.20	11	907	435	18	387	186	25	1,345	645	22
Fall River	364	45	25	8.09	9	434	329	31	454	345	4	792	601	26
Fitchburg	384	251	33	1.53	24	668	449	11	340	229	14	763	513	28
Foxborough	216	61	7	3.54	17	284	426	22	147	221	17	344	516	27
Franklin	188	17	15	11.06	5	220	401	25	151	275	8	335	611	25
Gardner	209	64	7	3.27	18	280	610	2	127	277	7	325	708	19
Government Center	432	165	57	2.62	20	654	353	29	494	267	10	1,154	623	24
Grafton	138	215	18	.64	37	371	445	14	163	195	22	347	416	33.5
Haverhill	307	70	23	4.39	13	400	427	21	203	217	19	1,151	1,228	1
Holyoke	431	8	57	53.80	1	496	324	32	292	191	24	1,092	713	18
Lawrence	448	81	29	5.53	12	558	443	15	306	243	12	407	323	37
Lowell	337	107	63	3.15	19	507	286	34	390	220	18	1,304	734	15
Lynn	577	57	72	10.10	7	706	501	8	402	286	5	650	462	32
Malden	444	184	74	2.41	22	702	422	23	249	150	31	1,213	730	16
Massachusetts Mental Health Center	378	285	72	1.33	28	735	357	28	303	147	32	1,555	755	12
Medfield	333	314	55	1.06	32	702	446	13	259	164	28	998	634	23
Metropolitan	382	294	36	1.30	29	712	578	5	264	214	20	922	748	14
Mystic Valley	222	252	48	.88	33	522	343	30	194	128	35	1,327	873	6
New Bedford	529	51	15	10.37	6	595	429	20	538	388	2	903	651	21
Newton	240	310	34	.77	35	584	461	10	197	155	30	921	727	17
Northampton	174	10	16	17.40	3	200	361	27	50	90	36	520	938	4.5
Plymouth	112	29	15	3.86	15	156	411	24	102	269	9	265	699	20
Reading	170	113	25	1.50	25.5	308	310	33	161	162	29	413	416	33.5
Southbridge	197	238	31	.83	34	466	463	9	145	144	33.5	476	473	31
South Shore	562	444	122	1.27	30	1,128	448	12	558	222	15.5	2,392	951	3
Springfield	709	36	99	19.69	2	844	284	35	1,034	348	3	2,853	961	2
Taunton	258	31	12	8.32	8	301	384	26	206	263	11	734	938	4.5
Tufts	564	228	60	2.47	21	852	1,480	1	290	167	27	500	869	7.5
Westborough	434	255	52	1.70	23	741	441	16.5	284	169	26	1,263	752	13
Worcester	622	879	60	.71	36	1,561	607	3	570	222	15.5	1,282	498	30
TOTALS	14,056	6,329	1,681	2.22		22,066	429		11,626	226		35,965	700	

[1] Data obtained from Mass. Dept. of Mental Health; T. Pugh and H. Wechsler, Dept. of Epidemiology, Harvard School of Public Health (Collected under NIMH Grant #MH 06599); and R. Notman, Mental Health Center Studies, Boston University.

[2] Data obtained from Mass. Dept. of Education.

[3] Per 100,000 population.

* Ratio State Hospital-Private Hospital admissions.

Appendix G

Measures of Social Pathology

Area	Total Arrests (1961)[1] No.	Rate[3]	Rank	Y.S.B. Commitments (1958-63)[2] No.	Rate[3]	Rank	Drunkenness (1963)[1] No.	Rate[3]	Rank	Narcotics (1963)[1] No.	Rate[3]	Rank
Barnstable	5,087	5,351	10	92	97	22.5	2,332	2,453	3	50	53	1
Berkshire	7,972	5,609	7	164	115	16	920	647	24	0	0	34.5
Boston State	9,995	4,325	13	435	189	5	1,341	583	27	15	7	11
Boston University	29,810	18,859	1	681	431	1	10,056	6,362	1	58	37	2
Brockton	7,056	3,806	17	221	119	15	1,581	853	17	4	2	23.5
Cambridge	19,037	9,405	2	307	152	8	3,518	1,738	6	19	9	9
Concord	1,475	3,895	16	15	40	34	154	407	30	0	0	34.5
Danvers	4,264	2,046	33	161	77	27	1,559	748	21	12	6	12.5
Fall River	4,471	3,394	22	137	104	19	1,299	986	15	0	0	34.5
Fitchburg	5,409	3,639	18	150	101	20	1,596	1,074	13	3	2	23.5
Foxborough	1,636	2,456	29	48	72	29.5	229	344	33	1	2	23.5
Franklin	1,471	2,681	26	80	146	10	262	478	28	1	2	23.5
Gardner	901	1,964	34	62	135	13	604	1,316	10	2	4	18
Government Center	16,566	8,946	3	421	227	2	4,557	2,461	4	35	18	3.5
Grafton	1,091	1,308	37	76	91	25	243	291	37	1	1	29
Haverhill	3,200	3,413	21	103	110	18	1,442	1,538	8	3	3	19.5
Holyoke	6,312	4,122	15	190	124	14	1,346	879	16	17	11	6
Lawrence	3,363	2,673	27	178	141	12	1,348	1,071	14	0	0	34.5
Lowell	9,290	5,233	11	171	96	24	2,220	1,250	11	1	1	29
Lynn	6,007	4,266	14	136	97	22.5	2,307	1,639	7	8	6	12.5
Malden	5,392	3,244	24	148	89	26	1,015	611	26	16	10	7
Massachusetts Mental Health Center	16,271	7,899	5	420	204	3	4,599	2,233	5	38	18	3.5
Medfield	2,391	1,518	36	26	17	37	538	342	34	0	0	34.5
Metropolitan	6,892	5,593	8	90	73	28	933	757	20	11	9	9
Mystic Valley	3,180	2,091	32	68	45	33	524	345	32	1	1	29
New Bedford	3,249	2,341	30	231	166	6	1,092	787	18	1	1	29
Newton	4,283	3,380	23	27	21	36	413	326	36	3	2	23.5
Northampton	1,984	3,579	19	55	99	21	355	640	25	0	0	34.5
Plymouth	1,309	3,453	20	43	113	17	294	776	19	5	13	5
Reading	1,709	1,721	35	63	63	31.5	339	341	35	5	5	15.5
Southbridge	4,514	4,484	12	146	145	11	706	701	23	3	3	19.5
South Shore	6,483	2,578	28	158	63	31.5	1,850	736	22	13	5	15.5
Springfield	20,420	6,880	6	450	152	8	3,469	1,169	12	15	5	15.5
Taunton	2,476	3,163	25	56	72	29.5	280	358	31	1	1	29
Tufts	5,030	8,739	4	117	203	4	1,973	3,428	2	5	9	9
Westborough	3,891	2,316	31	66	39	35	773	460	29	8	5	15.5
Worcester	14,175	5,509	9	390	152	8	3,574	1,389	9	5	2	23.5
TOTALS	248,022	4,825		6,382	124		61,641	1,199		360	7	

[1] Data obtained from Mass. Dept. of Corrections.
[2] Data obtained from Mass. Youth Service Board.
[3] Per 100,000 people.

Appendix H

Welfare Indices[1]

Area	Old Age Assist. No.	Old Age Assist. Rate[3]	Old Age Assist. Rank	Med. Aid Aged No.	Med. Aid Aged Rate[3]	Med. Aid Aged Rank	Disability Assist. No.	Disability Assist. Rate[3]	Disability Assist. Rank	Aid Depend. Child. No.	Aid Depend. Child. Rate[3]	Aid Depend. Child. Rank	General Relief No.	General Relief Rate[3]	General Relief Rank
Barnstable	864	909	20	369	388	22	143	150	22	1,013	1,066	15	230	242	21
Berkshire	1,509	1,062	16	582	409	20	253	178	18	1,539	1,083	14	972	684	4
Boston State[2]	1,771	769	27	1,346	585	7	411	179	17	5,065	2,200	4	377	164	28
Boston University[2]	4,114	2,603	1	2,328	1,473	1	1,420	898	1	8,638	5,465	1	1,300	822	1
Brockton	1,940	1,046	15	777	419	19	320	173	19	1,706	920	19	385	208	24
Cambridge	2,442	1,206	12	1,006	497	16	416	206	13	2,968	1,466	8	756	373	11
Concord	181	478	34	117	309	31	32	85	32	162	428	32	18	48	36
Danvers	1,796	862	23	652	313	30	291	140	25	1,619	777	21	475	228	22
Fall River	2,268	1,722	5	767	582	8	429	326	6	1,776	1,348	9	648	492	7
Fitchburg	1,169	787	26	483	325	27	245	165	20	1,004	675	25	390	262	19
Foxborough	446	669	28	196	294	34	75	113	28	358	537	27	215	323	13
Franklin	616	1,123	14	311	567	9.5	111	202	14	629	1,146	13	122	222	23
Gardner	419	913	19	182	397	21	68	148	23	314	684	24	137	298	16
Government Center[2]	3,061	1,653	6	1,214	656	4	692	374	3	2,954	1,595	6	315	170	27
Grafton	718	861	24	382	458	17	128	153	21	431	517	29	126	151	29
Haverhill	1,389	1,481	8	570	608	6	199	212	12	951	1,014	17	458	488	8
Holyoke	1,373	897	21	459	300	32	142	93	29	944	616	26	777	507	6
Lawrence	1,981	1,574	7	650	517	15	308	245	8	967	768	22	405	322	14
Lowell	2,472	1,392	10	989	557	11	397	224	10.5	1,696	955	18	608	342	12
Lynn	2,039	1,448	9	729	518	14	315	224	10.5	1,891	1,343	10	1,003	712	3
Malden	2,896	1,743	4	1,061	638	5	490	295	7	2,616	1,574	7	325	196	25
Massachusetts Mental Health Center[2]	2,678	1,300	11	1,780	864	3	724	351	5	5,675	2,755	3	522	253	20
Medfield	675	428	36	412	261	36	105	66	36	346	220	36	115	73	32
Metropolitan	788	640	29	426	346	25	150	122	27	568	461	30	68	55	35
Mystic Valley	717	472	35	423	278	35	107	70	35	664	437	31	155	102	30
New Bedford	2,917	2,102	3	768	553	12	510	367	4	2,448	1,764	5	595	429	9
Newton	463	365	37	296	234	37	78	62	37	149	118	37	56	44	37
Northampton	281	507	33	163	294	33	49	88	30	214	386	34	96	173	26
Plymouth	454	1,198	13	215	567	9.5	71	187	15	390	1,029	16	151	398	10
Reading	562	566	31	339	341	26	83	84	33	330	332	35	58	58	34
Southbridge	972	965	18	445	442	18	182	181	16	728	723	23	275	273	17
South Shore	1,465	583	30	958	381	23	217	86	31	1,311	521	28	160	64	33
Springfield	2,404	810	25	1,091	366	24	403	136	26	3,586	1,208	12	1,696	571	5
Taunton	697	890	22	254	324	28	112	143	24	692	884	20	234	299	15
Tufts[2]	1,349	2,344	2	546	947	2	485	843	2	2,451	4,258	2	446	775	2
Westborough	919	547	32	535	319	29	125	74	34	656	391	33	163	97	31
Worcester	2,518	979	17	1,340	521	13	605	235	9	3,162	1,229	11	681	265	18
TOTALS	55,323	1,076		25,165	490		10,891	212		62,611	1,218		15,514	302	

[1] Data obtained from October 1963 Report of Mass. Dept. of Public Welfare.
[2] Data obtained from June 1964 Report of Boston Welfare Department.
[3] Per 100,000 people.

Appendix I

Dissents

The Procedures of the Advisory Council of the Massachusetts Mental Health Planning Project includes in its sections a description of its functions and duties. This section reads as follows:

> "The Advisory Council shall receive all task force reports, and it shall receive from the Steering Committee a draft of the final report of the Advisory Council prepared in accordance with a procedure hereinafter described. It shall approve, disapprove, or modify the final draft of the final report of the Advisory Council and shall prepare a final draft of said report. It shall transmit, over the signatures of its members, the final draft of the report and any appropriate minority reports. . . . "

Four dissenting statements relating to three areas of recommendations were received. The following statement refers to the various references made throughout the report to the location of comprehensive community mental health centers in general hospitals and in particular to the recommendation in the chapter on the Adult Mentally Ill.

> "The opportunity to participate, under your direction, in comprehensive long-range planning of mental health services for the Commonwealth of Massachusetts has been a challenging, yet exhilarating, experience for members of the Advisory Council. We, the undersigned, want you to know the Council's report, and in the main its recommendations, have our enthusiastic endorsement.
>
> "We must take exception, however, to the recommendation in the section on the Adult Mentally Ill that 'local general hospitals should be given high priority as possible sites for the establishment of community mental health centers.'
>
> "We believe the major thrust of the mental health movement today is toward the community and away from the hospital. Its ultimate goal is promotion of health as much as treatment of illness. The modern community mental health center is dedicated to the prevention of hospitalization through early detection of emotional problems, outpatient services to children, collaboration with responsible citizens in reducing community tensions, and constructive intervention in community affairs. Even in the presence of illness, we have come to recognize the futility of 'warehousing' patients in mental hospitals. Current practice emphasizes speedy discharge to outpatient treatment, 'halfway houses,' and other methods of maintaining the mental patient insofar as possible in the community amid normal family and social relationships. The key to mental health care is the cultivation of self-reliance and the patient's ability to cope with stress. The identification of mental health services with hospitals can only serve to reinforce the patient's acceptance of illness and dependency and to discourage involvement with the 'normal' community.
>
> "We recognize that some facilities for inpatient care must be provided by, or available to, a comprehensive mental health program. We view this, however, as a subsidiary resource. The community mental health center should have a bed-care annex rather than be annexed to a general hospital. It should symbolize emotional health and vitality in community life rather than pain and disablement. We would prefer to recommend that community mental health centers be housed in hospitals only as an expedient, preferably temporary, when local circumstances make the development of independent facilities impractical."
>
> CHESTER BENNETT, PH.D.
> ANNE ROE, PH.D.

The following statement refers to the chapter on Epilepsy.

> "A comprehensive mental health center should include provisions for the treatment of epilepsy, which is a neuropsychiatric illness. Early diagnosis and treatment of all psychiatric illness is probably our best preventive measure. In epilepsy, as in many other psychiatric illnesses, proper diagnosis and treatment cannot be carried out without neurological evaluation and the use of drugs affecting the nervous system. These drugs now come under the general heading of psychopharmacology. Incorporation of neurological services in a community mental health center will enable that center not only to practice good psychiatry today but also will prepare it for the future, in which I believe the trend will be toward neuropsychiatry."
>
> ROBERT E. ARNOT, M.D.

The following statement refers to the chapter on Administration and Citizen Participation.

> "1. Reorganization of the Department of Mental Health is essential, but a proper plan would depend upon a survey by a firm of business management consultants.
>
> "2. Decentralization is most important, but this should mean decentralization all the way to the community level with local responsibility and local control.
>
> "3. The establishment of regional administrative structures would be a mistake. The present state hospital superintendents and the future Community Mental Health Center Medical Directors would resent the interposition of administrators between them and the Commissioner of Mental Health. Supermen would be needed. Psychiatrists could probably not be found for the positions, so that lay regional administrators would be over local physician administrators.
>
> "4. A regional developer of mental health programs could be considered. This person would have no administrative power. He would serve in a consultative role in the communities.
>
> "5. The correct titles for the directors of the Community Mental Health Center should be Medical Director and Executive Administrator. The Medical Director, a psychiatrist, would be in

charge rather than the lay person. Lay administrators have been tried at the state hospitals in Minnesota, and, as I understand it, have not succeeded.

"6. The psychiatrist who is the Medical Director should have a broad, eclectic approach to psychiatry so that these Community Mental Health Centers will not become either psychoanalytic temples or biologic institutes with minimal understanding of psychological and sociological factors.

"7. The Governing Board of the Community Mental Health Center should consist of 12 members at least 3 of whom should be physicians. The larger board of 30 mentioned in the report would not be effective. This Governing Board should have real administrative power.

"8. The existing state hospital trustees should not be removed, or weakened but rather should be strengthened. If they become a Community Mental Health Center Governing Board the remarks of statement No. 7 would apply.

"9. A Community Mental Health Planning Committee consisting of 20 to 40 local citizens, including physicians, should be established in each community. This would be a voluntary committee composed of individuals representing all the agencies and professionals working in mental health; for example, Family Service, Poverty Program, educators, and practicing psychiatrists. The Committee would determine what the mental health needs of a given community really are and would advise the Governing Board of the Community Mental Health Center as to how that Center could best help. Financing for this Planning Committee would come from various sources, such as the city or town government and even the state. An example of such a committee already in existence is the Metropolitan Boston Mental Health Planning Committee. The District Branches of the Massachusetts Medical Society could help sponsor these Community Mental Health Planning Committees.

"10. The Massachusetts Mental Health Association and the local mental health associations, whether or not they are affiliated with the statewide organization could nominate delegates both to the Governing Board and to the Planning Committee. In some instances the mental health association might expand to become the Planning Committee.

"11. Advisory Councils or Advisory Groups such as those recommended in this report to be appointed by the Commissioner to various levels of the Department of Health are of little real value. They serve chiefly as window dressing for citizen participation. Opinions tend to cancel each other. Without real power or responsibility the members lose interest. Consultants would be of more value."

ROBERT E. ARNOT, M.D.

The following statement refers to the chapter on Administration and Citizen Participation.

"In commenting on the report of the Planning Project, I find that I am in agreement with the overwhelming majority of recommendations it contains, especially in regard to greater citizen participation at the community level. The one key exception is in regard to the description of the functions and responsibilities of the area and regional mental health boards which I believe should be given more autonomy and authority for decision-making and budget control. The area and regional boards would increase the needed communication between the state mental health authority, the mental hospitals and the local communities. The Planning Project is to be commended for its proposals aimed at implementing the need for this greater communication and integration of services for both community care and chronic care.

"As President of the Massachusetts Association for Mental Health, I would like to note the elements of the community program which our Association has emphasized as essential:

"1. Community mental health programs should be administered by Community Mental Health Boards established by law and whose membership will come from the towns and cities served. These boards would have responsibility for basic policy with respect to programs and services and would receive funds from state and local government and disburse them to agencies providing services within the areas covered. The preponderant majority of the board members would be appointed by local elected officials and would include representatives from health and welfare agencies. The boards shall have professional staff to carry out their policies.

"2. The Department of Mental Health should extend its planning, regulatory, consultative and standards setting functions, and gradually decentralize and limit its provision of direct patient services. It also should encourage research, experimentation and training of personnel.

"3. Enabling legislation should be permissive but sufficiently structured to establish a direction for development.

"4. Although any segment of a community program would have to conform to criteria of the Department of Mental Health before it qualifies for support, needs of a community might warrant differences in total programs. Opportunity for innovation and competition should be fostered.

"5. Care of chronic patients in large institutions should be included within the area of responsibility of community mental health boards which could be achieved through the establishment of administrative, financial and joint staffing arrangements."

PLINY JEWELL, JR.